REPORT

THE COMMISSION ON THE TREATMENT AND CARE OF PEOPLE AFFLICTED WITH PHYSICAL OR MENTAL DISABILITIES

1940

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Printed under authority of Section 142,
General Statutes of Connecticut,
Revision of 1930.

JOHN M. DOWE,
State Comptroller

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To His Excellency,
The Governor of the State of Connecticut

The Commission on the Treatment and Care of People Afflicted With Physical or Mental Disabilities, created by Special Act 548 passed by the General Assembly of 1939, respectfully submits herewith its report and legislative proposals as required by law.

CREIGHTON BARKER, M.D., *Chairman*
WILMAR M. ALLEN, M.D.
JOSEPH B. DOWNES
IRA V. HISCOCK
LUCIUS F. ROBINSON, JR.

WILLIAM H. COON, M.D.
Coordinating Director

FOREWORD

The General Assembly of 1939, by the passage of Special Act 548, created a Commission on the Treatment and Care of People Afflicted With Physical or Mental Disabilities.

"An Act Creating A Commission On The Treatment And Care Of People Afflicted With Physical Or Mental Disabilities.

"Section 1. There is created a commission on the treatment and care of the people of the state afflicted with physical and mental disabilities. Said commission shall consist of five residents of the state, to be appointed by the governor, to hold office until January 1, 1941. The members of said commission shall receive no compensation for their services, but their necessary expenses shall be paid by the state upon certification by the chairman, and with the approval of the governor and the commissioner of finance and control, said commission may employ and fix the compensation of such clerical and other assistants as it may, from time to time, require and appoint.

"Section 2. The commission shall study the problems presented by the physical and mental disabilities of the people of the state, and inquire into the subject of the expenditures made, or, in the opinion of the commission, necessary to be made, by the state for the prevention of such disabilities and the care of the people afflicted thereby.

"Section 3. For the purpose of carrying out the provisions of this act, said commission may hold either public or private hearings, by majority vote and under signature of the chairman, issue subpoenas in the usual manner, requiring the appearance before it, for examination under oath, of any director, trustee, officer or employee of any state institution or other state agency or any other person and by such process and in the same manner, may compel the production of the books, papers and other documents of any state institution or agency thereof, so far as the same shall be pertinent to the purposes of this act.

"Section 4. Said commission shall report its findings and its recommendations to the governor, on or before January 1, 1941, and shall embody in such report drafts for legislation necessary to carry such recommendations into effect."

The Commission was created in recognition, by the General Assembly, of the need for a study of the whole complex pattern of the public care of the sick, which involves the annual expenditure of many millions of dollars of public funds and affects the welfare and happiness of thousands of citizens of Connecticut.

In compliance with the Special Act, Governor Baldwin first appointed to serve on the Commission:

Honorable Kenneth Wynne, Judge of the Superior Court, New Haven, Chairman

Wilmar M. Allen, M.D., Director, Hartford Hospital, Hartford

Creighton Barker, M.D., Executive Secretary, Connecticut State Medical Society, New Haven

William H. Coon, M.D., Member 1939 General Assembly, Easton

John A. Markham, Attorney-at-law, Hartford.

Soon after the Commission organized, Mr. Markham resigned to represent the Commission as its attorney, and Senator Joseph B. Downes of Norwich was appointed to succeed him. Mr. Markham continued as the Commission's attorney until the completion of the study of conditions at the Norwich State Hospital.

Before the Norwich study was completed, Judge Wynne resigned and Professor Ira V. Hiscock of the Department of Public Health at Yale University was appointed as his successor, and Dr. Creighton Barker became the Chairman of the Commission.

Somewhat later, Dr. Coon resigned from the Commission to become its Coordinating Director, and Mr. Lucius F. Robinson, Jr., Attorney- at-law, Hartford, was named to succeed Dr.Coon.

Finally the Commission was organized as follows and has continued without change:

Creighton Barker, M.D., Executive Secretary, Connecticut State Medical Society, New Haven, Chairman

Wilmar M. Allen, M.D., Director, Hartford Hospital, Hartford

Honorable Joseph B. Downes, Norwich

Ira V. Hiscock, Sc. D., Professor of Public Health, Yale University, New Haven

Lucius F. Robinson, Jr., Attorney-at-law, Hartford.

INTRODUCTION

Any study of the health conditions in this state or consideration of a program to meet future health and welfare needs must be based upon an understanding of what the State of Connecticut is. This understanding should include both an assessment of real values as to the state itself, and a comparison of those values in relation to other states in the nation.

In area, Connecticut is the third smallest state in the Union; in population it is about the 30th. This population is distributed at the rate of 357 persons per square mile which, in comparison to the nation as a whole, is relatively dense. The population of the state has increased only moderately in the past ten years, showing an increase that is less than the increase for the entire country. Although the state's population is now nearly static and of late years there has been little migration here, the state's foreign-born white population in proportion to the total population is over twice as high as that for the nation as a whole. The Negro population in the state is less than two per cent in comparison to a Negro population of ten percent for the entire country. These factors are of importance in connection with any consideration of health and welfare problems.

Economically the State of Connecticut occupies a fortunate and enviable position. The income per capita is relatively high as is the per capita assessed valuation of property. The State ranks fourth among the other states in the number of persons paying federal income taxes per thousand of population, and has lately stood eleventh among the states in the gross amount of federal taxes paid. Other factors are of interest in determining the relative economic status of this state. Connecticut ranks sixth among the states in value of retail sales per capita, and fourth among the states in the number of passenger automobiles owned per thousand of population. During the worst of the recent depression it ranked midway between the highest and the lowest of the states in percentage of unemployment. A recent study which compared all of these factors and established the relative per capita purchasing power of the states, placed Connecticut eighth on the list. (In these computations the District of Columbia is excluded.)

From the standpoint of medical service, the state is fortunately situated also. The quality of medical care has long been safeguarded by rigid and intelligent laws regulating the licensing of physicians. In the number of physicians in relation to the population Connecticut ranks ninth among the states. There is no shortage of available medical care, for the number of physicians in proportion to the population

is above the average for the country as a whole. During the past two decades there has been a tendency for physicians to concentrate in urban centers, but this did not become serious here. Now, with a definite move toward rural and suburban residence there is a significant interest in locations in small towns and villages shown by young physicians starting in practice. The distribution of physicians follows the simple laws of demand and supply and except for some thinly inhabited areas in the eastern counties, the state is well supplied with doctors.

In the field of hospitalization there is a fully adequate number of units and these are so located that there is no point in the state that is more than twenty-five miles from a modern, well-equipped and well-staffed hospital. The hospitalization of illness has increased rapidly of late years and in communities like Connecticut this increase has been most marked so that although the number of general hospital beds in proportion to the population in this state is well above average for the country and above the minimum standard set for adequate hospitalization, the institutions here are usually filled nearly to capacity and there is need for additional beds, particularly those that can be used for the special purposes that will be discussed later.

The State Health Department has been well organized and administered for many years. Connecticut enjoys a favored place in the public health field. While it is not exactly accurate to say that public health measures alone determine the death rate of a community without giving consideration to living conditions and economic factors, mortality rates are an index of the effectiveness of a public health program.

When viewed statistically, Connecticut is a healthy state, one of the healthiest in the Union, and improvement has been consistently shown year after year. If, for example, the 1915 rates had prevailed in 1938, there would have been nearly 300 deaths in the latter year from diphtheria instead of 12, and 2500 deaths from tuberculosis instead of 616; the number of babies who now die before reaching their first birthday is only two-fifths of what it was twenty-five years ago. Typhoid fever has been nearly wiped out and smallpox is a medical curiosity. These life-saving measures and improved medical care have inevitably had the effect of increasing the span of life, for, as the health of the people improves, the average of life increases accordingly. Commencing between 1900 and 1910 it became fixedly apparent that the span of life was increasing. By 1920 that trend had vigorously asserted itself and has continued. In 1900 the average age at death for persons in this state was 38 years; in 1937 that figure had increased to 58 years. This increase in longevity is not peculiar to Connecticut but is a trend that has been experienced throughout the nation; indeed the average age at death in this state is slightly below the life expectancy for the United States. However, because the state has a nearly static population and

a birth rate that has remained at a relatively low level, and because there has been no influx of young migrants for some time, Connecticut has a larger proportion of persons in the older age groups than does the country as a whole. This factor of an ageing population is of special interest in connection with health, for in these advanced age periods certain diseases become inevitable. Infant mortality and deaths from the acute diseases of childhood and from typhoid have been reduced to a minimum and mortality from tuberculosis, from the acute pneumonias and during childbirth and from many other causes has been sharply lowered by the wise application of proven public health measures.

Now the state stands at the threshold of an era when its attention and its expenditures must be especially directed to the care of its charges who are suffering from the diseases that come with advancing years. Diseases of the heart and blood vessels are rapidly mounting as the greatest cause of death; the increasing mortality from cancer now accounts for four times as many deaths as tuberculosis, and over twenty-five percent of admissions to state hospitals for the insane are over sixty years of age. These diseases may only in part be forestalled and prevented and finally the sufferer will require care. No effort should be spared to hold the solid ground that has been gained in the control of other sickness, but the years that lie ahead present a challenge to the state to provide a wise program for the care of its citizens who are overtaken by physical misfortune in their later years.

This Commission is mindful that many mental and physical disabilities are closely related to such basic problems as eugenics, sociology and economics. Better solution of these fundamental questions will be necessary for the establishment of an adequate program for the prevention of mental and physical disabilities, but this is beyond the scope of this Commission.

ACKNOWLEDGEMENT

Acknowledgement is here made to the many public officials and citizens in the State of Connecticut and elsewhere who have, through their contributions, extended the knowledge and furthered the objectives of this Commission.

RECOMMENDATIONS

I

THE CARE OF THE MENTALLY SICK

A. **A Council on Mental Health.** This Commission recommends an agency of government to be known as the Council on Mental Health. The function of this Council shall be to coordinate the administration of the hospitals for the care of the mentally sick and the mentally deficient and to direct a state program for the care and prevention of mental illness.

COMMENT: The development of Connecticut's solution to the care of the mentally sick and the mentally deficient has been uneven and with little study of the future needs of the state. The major reason for this is a lack of a unified state-wide program. The time has come when the program and planning in this field should be coordinated. (See page 26)

B. **Commitment to State Hospitals.** This Commission recommends amendment of the statutes providing for the commitment of the insane to clarify the status of emergency detention, to provide for admission of patients to state hospitals on certificate, and to require examination by approved psychiatrists in the commitment procedure.

COMMENT: The admission of proper cases to state hospitals for the insane should be expedited, but on the other hand, obstacles should be interposed to the admission of patients who should not be confined in such hospitals. In practice the original intent of the statute providing for emergency admissions has not been served, and the recommendations herein proposed seek to correct that abuse and provide an additional means by which patients may be expeditiously admitted to state hospitals. (See page 31)

C. **Preventive Measures in Mental Disease.** This Commission recommends that the Council on Mental Health direct its attention to the establishment of out-patient clinics and other preventive measures in connection with the state hospitals for mental diseases; and further recommends that the Bureau of Mental Hygiene of the State Department of Health, in cooperation with the Council on Mental Health, extend its limited provisions for psychiatric clinic service.

COMMENT: The state program is deficient in means directed toward the prevention of mental illness. This recommendation is made with three objectives: to serve the best interests of the patient himself through early diagnosis and social adjustment; to relieve overcrowding in the institutions; to reduce the ultimate cost to the state of institutional care. (See page 26)

D. **The Care of Inebriates and Drug Addicts.** This Commission recommends that immediate steps be taken by the Council on Mental Health to provide facilities for the care of inebriates and drug addicts.

COMMENT: The General Assembly of 1939 abolished the State Farm for Inebriates. (Sec. 580c, 1939 Supplement) No substitute for the care and treatment of such persons was provided. The problem in respect thereof is a substantial and continuing one which will require study and solution.
(See page 26)

II

THE CARE OF THE CHRONICALLY SICK AND DISABLED

A. **A State Program for the Care of the Chronically Sick.** This Commission urges that provision be made for the care of persons chronically sick or disabled with cancer, arthritis, heart disease, degenerative disease and other conditions, and to this end recommends that a commission be appointed to continue the study of this problem and to submit recommendations for the necessary program.

COMMENT: In the eyes of the public — and in this the Commission is in agreement — the most pressing health and welfare problem that now confronts the state is the provision of facilities for the care of the chronically sick among the indigent and low-income classes. It is believed that this may be best answered by the utilization of accommodations in connection with existing general hospitals rather than by the construction and maintenance of a state infirmary. Because this problem is one of such magnitude, and involves the determination of new policy on the part of the state and the expenditure of a considerable capital sum, this Commission does not believe that it is equipped or empowered to proceed.
(See page 34)

B. **State Aid to General Hospitals.** This Commission recommends that no state-aided general hospital shall receive less than the approximate average cost for the care of state charges.

COMMENT: It is realized that certain hospitals must continue to receive a grant from the state if they are to exist, but additional funds should be paid to voluntary hospitals that suffer a loss through the care of state charges.
(See page 39)

C. **A Custodial Care Institution at Mystic.** This Commission recommends that the plant of the Mystic Oral School be utilized for the reception of those patients in state mental hospitals who require only custodial care.

COMMENT: There are many hundreds of persons, mostly aged, who are now patients in hospitals for the insane who do not require the specialized psychiatric care provided by such hospitals. These persons will need custodial care for the rest of their days, and their presence in hospitals that have been primarily established for the care of the insane overcrowds those hospitals and renders increasingly difficult the treatment of psychiatric patients who may be benefited by such treatment. (See page 41)

III

THE CARE AND PREVENTION OF TUBERCULOSIS

A. **Extension of the Functions of the Tuberculosis Commission.** This Commission recommends that the powers and functions of the Tuberculosis Commission be extended to include the instruction of the people of the state in the rules of living essential to the suppression of tuberculosis, and to provide and maintain within or apart from the state sanatoria facilities and personnel for the detection of tuberculosis in its early stages and the rehabilitation of the tuberculous.

COMMENT: A survey made by this Commission of the experience of the state sanitoria shows that the preponderating number of admissions to these institutions comes within the classification of moderately advanced and far advanced cases, and that the trend of admissions is within these groups. The admission of minimal or incipient cases remains at a low level. If the sanatoria are to perform efficiently the functions for which they were conceived, and if deaths from tuberculosis in this state are to be further controlled, it is essential that tuberculosis be apprehended in its early stages. This objective lies largely within a properly designed and administered educational and case finding program. (See page 43)

IV

THE CARE AND EDUCATION OF THE DEAF AND BLIND

A. **The Discontinuance of the Mystic Oral School.** This Commission recommends that the Mystic Oral School be discontinued and that the state program for the education of the deaf be consolidated in the American School for the Deaf, West Hartford.

COMMENT: There appears to be no necessity for the continuance of the Oral School at Mystic since the state's comparatively small problem of the education of the deaf can be adequately and economically met by its consolidation with the American School for the Deaf in one institution. (See page 50)

B. **Addition of State Officials to the Board of Directors of the American School for the Deaf.** This Commission recommends that the Commissioner of Education and the Commissioner of Finance and Control be added to the Board of Directors of the American School for the Deaf.

COMMENT: The state has a large capital and functional interest in the American School for the Deaf and that interest should be recognized by adding representatives from the government of the state to the governing authority of the American School. (See page 52)

C. **Admission of Pupils to Schools for the Education of the Deaf.** This Commission recommends that the Commissioner of Education or his representative be designated the authority to admit state-supported pupils to institutions for the education of the deaf.

COMMENT: The present statutory provision entrusting to the Governor the authority to admit children to the schools for the deaf is inadequate in that no examination of the prospective pupil is required. There is evidence that children have been improperly placed in these institutions because of this lack of investigation before admission. (See page 53)

D. **Care and Education of the Blind.** This Commission recommends a continuation of the program for the care of the blind as now administered by the State Board of Education of the Blind, and extending those measures as necessity arises. It is further recommended that the provision of sight-conservation classes in the public schools be enlarged to meet existing needs.

COMMENT: According to accepted standards, the number and distribution of sight-conservation classes in the public school system is inadequate and in their extension lies an opportunity to be of great service to that small, courageous segment of the population that cannot see. (See page 54)

V

CANCER

A. **Research and Statistics.** This Commission recommends that there be appropriated to the State Department of Health for the purpose of aiding in the maintenance and administration of clinics for cancer study and treatment a sum sufficient for that purpose.

COMMENT: The population of Connecticut is aging and with that has come an increase in certain diseases of which cancer is the most important from a public health standpoint. Cancer now accounts for the second largest number of deaths in this state, and until science provides a more dependable method for relief than is now known, cancer will continue to be an increasing factor in the sickness and death experience of the people. Hope lies in the early diagnosis of the disease. Clinics are conducted in many hospitals in the state in cooperation with the State Department of Health to provide early diagnosis and treatment. The state will be richly served by financial assurance that these clinics may be continued and their services extended. (See page 56)

VI

FOOD AND MILK PRODUCTS

A. **Supervision.** This Commission recommends that responsibility for the sanitary control and supervision of foods, including meat, milk and milk products, and the supervision of eating and drinking establishments, be placed within the State Department of Health.

COMMENT: The sanitary control of food and milk products is a first requisite in the protection of the health of the people. For this reason provisions for the prevention of outbreaks of diseases which may be spread through these channels should be administered by the State Department of Health—the department best qualified to serve this function. (See page 58)

VII

HEALTH IN INDUSTRY

A. **Protection of the Health of Industrial Workers.** This Commission recommends the further safeguarding of the health of workers in industry by appropriately extending the program of the Bureau of Occupational Diseases of the State Department of Health.

COMMENT: With the constantly growing demand for consultive service by the Bureau of Occupational Diseases, accelerated by increasing industrial activity, both labor and industry will be better served by an extension of that Bureau's facilities.

VIII

QUALIFICATIONS AND EMPLOYMENT OF PERSONNEL IN HEALTH SERVICE

A. **Qualifications for the State Commissioner of Health.** This Commission recommends that the qualifications specified in the statutes for the State Commissioner of Health be amended so as to include the requirement that the Commissioner shall have had a minimum of one year of university graduate instruction in public health, as evidenced by a certificate of graduation or a degree in public health.

COMMENT: The extension of public health knowledge and education has created a definite profession within public health science, and although a background of medicine is a requisite for a public health official, the more successful and efficient administrator will be trained beyond the field of clinical medicine. (See page 60)

B. **Educational Requirements in the Merit System Law.** This Commission recommends that the Merit System Law be amended to provide for an educational requirement for physicians and dentists employed by the state. (See page 62)

C. **Non-assembled Examinations.** This Commission recommends that the Director of Personnel make provision for non-assembled examinations for physicians in the State Merit System. (See page 62)

D. **Periodic Salary Increases.** This Commission recommends that the Commissioner of Finance and Control make provision for periodic salary increases for physicians and other institutional and Health Department personnel in the classified service. (See page 62)

E. **Maintenance.** This Commission, recognizing the inequities of the present method for computing maintenance allowances for employees, recommends that the Commissioner of Finance and Control revise the method for computing such allowances, and in the interests of the employee and the state clearly define the limitations of maintenance.

IX

THE LICENSING OF PRACTITIONERS OF THE HEALING ARTS

A. **Standards for Licensure.** This Commission recommends, for the protection of the health of the people of this state, that the present high standards for practitioners of the healing arts, as now provided in the statutes, be maintained. (See page 67)

THE CARE OF THE MENTALLY SICK

There were in the year 1900, 2,078 persons resident as patients in the one (Middletown) state mental hospital in Connecticut. In the year 1940 this number had increased to 7,532 in the three institutions now maintained by the state, one at Middletown, one at Norwich and one at Newtown.

The following table shows the number of patients under treatment in the hospitals at the end of each of the given fiscal years:

1900	*1905*	*1910*	*1915*	*1920*	*1925*	*1930*	*1935*	*1940*
2078	2572	3078	3856	4206	4941	5572	6822	7532

The number of patients housed in these institutions for each 100,000 of the population of the state was as follows:

1900	*1905*	*1910*	*1915*	*1920*	*1925*	*1930*	*1935*	*1940*
228	259	276	310	301	323	345	395	412

The patient population of the hospitals has increased by eighty per cent over the increase in the population of the state for the period recorded.

Parallel with the increase in hospital population has come, likewise, an increase in the number of first admissions to these institutions, as shown by the following:

Five Year Periods*

	1921–24	*1925–29*	*1930–34*	*1935–39*
Average number yearly first admissions	814	941	1055	1237

*First admissions not given at Norwich until the year 1921.

First admissions for the period 1935-39 show an increase of 52 per cent over the period 1921-24.

In comparison with the average population of the state for each of the given five year periods, the first admissions to state mental hospitals have been:

Five Year Periods

	*1921–24**	*1925–29*	*1930–34*	*1935–39*
Average yearly first admissions per 100,000 of population	55	59	63	70

*Four year period.

This is an increase of 27 per cent for the period 1935-39 over the period 1921-24.

The average yearly increase in the number of patients resident in state mental hospitals for the years 1900-1940 is 136. This increase, while of uneven distribution, has nevertheless shown a marked acceleration in the last ten years. For this period the hospital population has increased annually by 200 patients. Thought must be given to the fact that if this increase in hospital population continues at the rate maintained for the last decade, the limit of tolerance of hospital occupancy will be reached within the next eight years. It seems evident that further capital expenditures for the institutional care of the mentally sick will be a necessity within this time unless means are taken to diminish the number of patients seeking admission to these hospitals and to accelerate the discharge of those under treatment in them.

At this time (1940) there are in the state mental hospitals of Connecticut accommodations for patients as follows:

Hospital	*Built to Accomodate*
Middletown	2,628
Norwich	2,600
Newtown	2,200
TOTAL	7,428**

**On June 30, 1940, there were on the books of these hospitals 7,532 patients, 7,007 of which were resident in the hospitals, while 525 were out of the hospitals on parole.

In its study of the state mental hospitals in Connecticut this Commission soon learned that there existed no statistical evidence that would give information concerning specific facts relating to each patient, how long he had been in the hospital, what his chances were for eventual recovery or release from the institution on parole, and other relevant facts concerning him. To obtain this information the Commission caused a survey to be made of all patients registered in the hospitals as of midnight on June 30, 1940. This information is presented below in summarized form.

Summary of Patients Resident in State

Mental Hospitals in Connecticut on June 30, 1940

Population — Sex — Color

On midnight of June 30, 1940 there were registered in the three state mental hospitals 7,532 persons, of whom 3,648 were men and 3,884 were women. A total of 7,293 were classified as white, 211 as Negroes and 28 were unclassified. There were 1,199 or 15.9 per cent classified as aliens.

Age Classification.

Only 801 or 10.6 per cent of all were under thirty years of age: 2,738 or 36.3 per cent were between thirty and fifty years of age, while 3,993 or 53 per cent were over fifty years of age. 2,186 or 28.7 per cent of all patients were over sixty years old.

Patient Admission to Mental Hospitals.

4,943 had been admitted to a mental hospital for the first time. 2,578 had been admitted to a mental hospital on two or more occasions. The number of admissions of 11 was not stated.

Length of Residence in Hospital.

396 had been resident in the hospitals for less than three months. 1,015 had been resident for less than one year. 1,533 had been in the hospital for from one to four years. 2,033 had been resident from four to ten years. 1,665 had been resident from ten to twenty years. 1,286 had been resident for over twenty years.

Eligibility for Parole or Boarding Out.

Of all persons (7,532) upon the registers of the hospital, 525 or 6.9 per cent were away from the hospitals on parole. 840 persons other than those on parole were stated to be in mental and physical condition suitable for boarding out, if such facilities were available for them.

Prognosis for Recovery of Patients in Hospitals.

5,829 or 77.3 per cent of all were stated to be in such physical and mental condition that their recovery was improbable: the recovery of 1,212 patients was stated to be a matter of uncertainty, while of 417 or 5.5 per cent of all, it was stated that their eventual recovery was probable. The prognosis of 74 patients was not stated.

It should be noted that of the 7,532 patients registered 4,984 or 66 per cent of all had been in the hospitals for four years or more. The statistics of the mental hospitals are not so arranged as to show the number of recoveries or paroles that appear among this group. A study of the reports of the mental hospitals of Massachusetts shows, however, that less than four per cent of recoveries or paroles are from the group that have been resident in hospitals for four years or more.

Another survey made by this Commission of the medical experience at the Middletown and Norwich Hospitals reveals a progressive increase in first admissions among persons over sixty years of age. For the period of 1920-1938 the percentage of admissions to Middletown in the over sixty year age group showed an increase of 25.8 per cent, and at Norwich for the same period and for the same group an increase of 25.7 per cent was shown. For the year ending June 30, 1939, 29.5 per cent of all first admissions to Middletown were over sixty years of age.

Of all first admissions to Middletown (8,566) for the years 1920-1938, 35.6 per cent were due either to psychoses associated with cerebral arterio sclerosis or to dementia praecox. Each of these causes has shown a marked tendency to increase as causes of first admissions. Over the years 1921-1938 at Middletown psychoses associated with cerebral arterio-sclerosis showed an increase of 278 per cent as causes of first admission, while dementia praecox as a cause of admission showed an increase of 102 per cent.

In its care and control of mental disease, the State of Connecticut is facing a situation characterized by: (a) a continually increasing number of patients in the state mental hospitals for whom recovery is improbable and for whom institutional facilities must always be maintained; (b) an increasing number of persons admitted yearly to these institutions, and associated with this increase in admissions; (c) an ever-increasing percentage of those who, when admitted, are over sixty years of age; (d) a yearly increase in the number of persons resident in these hospitals that will, under the present rate of progression, require within the next ten years additional hospital facilities for their care and treatment.

This increase in hospital population year by year is due to a definite increase in the length of hospital stay of patients with mental disorders and the inability of the hospitals to discharge from the institutions a number equal to those admitted to them.

These conditions are not new. They have progressed over many years and the evidence of their effect has become so cumulative that consideration must now be given to future plans. Up to this time the state as a unit has given little or no thought to the control of mental disease as a state-wide problem, although it has provided for the reception of the mentally ill at the Norwich Hospital and at the Connecticut State Hospital at Middletown. The newly-constructed hospital at Newtown is now serving to relieve the overcrowding that prevails at the other two hospitals. However, neither the state nor any of its agencies has approached the situation with a view to considering the problem as a whole.

That such a program shall become operative, this Commission has recommended the establishment of a "Council on Mental Health" which shall take into consideration all those factors having to do with mental illness and its care.

Such an agency should be an alert organization constantly studying all means of reaching higher standards, and concerning itself not primarily with the administration of the mental hospitals, but exercising constant vigilance to see that these standards are maintained. It should be equally alert in the recognition of all those measures necessary to insure the detection of mental disease in its early stages, to

restrict admission to mental hospitals to those for whom the hospitals may be of service, and to consider provisions for those who may properly be cared for outside of the hospitals.

Evidence has been presented to this Commission that of all persons admitted to the state mental hospitals for the first time, few have either sought or received any psychiatric advice or assistance. Evidence equally clear has been presented that many persons are admitted to mental hospitals each year in this state whose only mental disabilities are those of advancing years, and who could and should be cared for outside these hospitals.

It is believed that the Council on Mental Health, devoting itself with diligence and understanding to the problems appearing before it, will postpone for some time the necessity for further institutional provisions for the care of the mentally ill in Connecticut.

THE CARE OF THE MENTALLY DEFICIENT

The problems associated with the mentally deficient in this state are not primarily those related to their care, treatment and education in state institutions. Connecticut maintains or will soon maintain at Mansfield and at Southbury, training school and hospital facilities for 2,400 persons who come under the broad classification of mental defectives, ranging from complete idiocy to those able to make some fairly satisfactory adjustment to their surroundings.

This number, however, for whom special training and hospital facilities are provided, represents but approximately nine per cent of the 26,000 who were found by a commission established in Connecticut to study the human resources of the state, to be either mentally deficient or epileptic. That this situation is not static but on the increase is evidenced by the fact that while in 1923 for the United States as a whole there were thirty-four persons for each one hundred thousand of the population in institutions for the mentally defective, this number had in 1934 increased to sixty-nine per hundred thousand, an increase under broad criteria of classification of over one hundred per cent.

There is presented a situation in which institutional provision has been made for a small part only of our mentally defective and epileptic population. In comparison with the states of New York and Massachusetts in its institutional provisions for this class, Connecticut stands as follows:

INSTITUTIONAL PROVISIONS FOR THE MENTALLY DEFECTIVE AND EPILEPTIC

State	*Present Normal Capacity*	*Capacity with Construction Completed*	*Completed Capacity per each 100,000 population*
New York (1938)	12,685	18,485	154
Massachusetts (1938)	6,402		142
Connecticut (1940)		2,400	142

It has been stated that institutions for the mentally defective are maintained for five purposes.

(1) To relieve the family and the community at large of the care of persons whose development is so retarded that they constitute a serious burden.

(2) To limit the propagation of the genetically inferior by segregation.

(3) To provide humane institutional care for persons of such low grade development that they cannot be restored to community life, and to furnish such persons with an environment in which they can live with a maximum of personal satisfaction.

(4) To rehabilitate such persons under care as are capable of material improvement, to prepare them for life outside the hospitals so far as is possible, and to place them in the community under supervision as soon as such placement can be wisely accomplished.

(5) To maintain research into the causes of mental deficiency.

This concept of the restoration of higher grade mental defectives to the normal life of the community was one of the precepts upon which Dr. W. E. Fernald, a pioneer in this field, instituted his program for the care of the mentally defective and which over the years has remained unchanged as an outline of effective procedure. On whatever premises the objectives of restoration have been based, it is of interest to observe to what point of productive effort the restoration of the mental defective to the community has been attained through the maintenance of hospital training schools devoted to this purpose. The measure of success of any program is to be found in the number of persons from any institution or group of institutions who have so profited by their training that they have been returned to the life of the community.

In this respect the following table is of interest.

PAROLES

Percentage of all patients on books of state institutions for the mentally defective, on parole at end of each fiscal year.

State:	NEW YORK	MASSACHUSETTS	CONNECTICUT
Year	*per cent of all patients on parole*	*per cent of all patients on parole*	*per cent of all patients on parole*
1926	14.4	10.3	8.9
1927	13.1	7.9	9.3
1928	12.0	7.5	13.9
1929	11.7	7.8	13.5
1930	11.4	7.1	12.3
1931	10.5	7.0	12.5
1932	8.6	5.9	9.0
1933	7.5	6.5	10.6
1934	8.9	7.1	11.4
1935	10.6	7.2	11.0
1936	10.5	7.7	12.3
1937	9.6	8.3	12.5
1938	10.2	7.6	11.2
1939	10.0		11.4
1940			10.8

From this tabulation it appears that in Massachusetts, in New York and in Connecticut the number of patients on parole from institutions for the mentally defective has, as expressed in percentage of those cared for, remained static.

The effective employment of these institutions as agencies for the restoration of the mental defective to the community has not been a matter of encouraging record. The failure in this objective of attainment cannot be laid to the training schools or to their methods of instruction but is found in the fact that the urgency of the situation as expressed in the large number of applicants for admission to these institutions, makes it difficult to select that class for whom training would be of most help.

There is at hand statistical evidence secured from a study of the State Training School and Hospital at Mansfield that should offer some enlightenment upon the limitation of influence of such an institution on the larger problems of mental deficiency.

This evidence indicates clearly the need for the adoption of other measures than those associated with institutional care and training if any productive approach is to be made to the problem associated with the mental defective from the standpoint of effective control.

At Mansfield on June 30, 1940 there were registered 1354 patients, classified by type as follows:

Characteristics of Patient Population at Mansfield by Intelligence Rating

	Male		*Female*		
Type of Classification	*Feeble-minded*	*Epileptic*	*Feeble-minded*	*Epileptic*	*Total*
Idiot	149	48	138	34	369
Imbecile	258	34	199	54	545
Moron	130	21	229	36	416
Borderline		6		6	12
Dull normal		2		2	4
Normal		3		2	5
Not classified			2	1	3
Total	537	114	568	135	1354

Of the above 1,354 there were classified:

Suitable for parole	261 or 19.2 per cent
Suitable for boarding out	171 or 12.5 per cent
Requiring institutional care	922 or 67.2 per cent

Note: While 261 were classified as suitable for parole, only 145 or 10.8 per cent were actually on parole at the time.

Of the 1354 patients 145 were on parole. The mental type of those on parole fell within these classifications:

Characteristics of Population on Parole

	Male		Female		
Type	*Feeble-minded*	*Epileptic*	*Feeble-minded*	*Epileptic*	*Total*
Idiot	7	2	5	1	15
Imbecile	24	2	14	3	43
Moron	27	4	43	6	80
Border line		3		1	4
Dull normal		1		0	1
Normal		0		2	2
Total	58	12	62	13	145

Among those on parole 58 were within the idiot-imbecile classification, for whom but little assurance of restoration could be entertained. In the school registration of 1354, 440 were classified as moron or higher grade. Of these, 87 or 19.5 per cent were on parole. Those on parole, however, coming within the classification of morons or higher grades, were accountable for but 6.4 per cent of the school registration.

This picture of an institution with 68 per cent of its number who require and will always require institutional care, with 12 per cent suitable for boarding out, and with but 10.7 per cent of its population on parole, is a reflection of conditions outside the institution as expressed by the umber and the characteristics of those awaiting admission to it.

It is stated that in 1922 there were "over 200 boys and girls" awaiting admission to Mansfield. In 1940 this number had increased to 1530, an apparent increase in eighteen years of over seven hundred per cent. The mental types of those 1530 on the waiting list are classified as follows:

Classification of Waiting List as of June 30, 1940

Intelligence Quotients		*Male*	*Female*	*Total*
Idiots	(0–25)	128	129	257
Imbeciles	(25–50)	295	313	608
Morons	(50–70)	237	305	542
Border line, dull normal, etc., over 70	(over 70)	59	33	92
I. Q. not known		8	23	31
Total		727	803	1530

Of those on this waiting list seeking admission to Mansfield and Southbury, well over half are of that type for whom no hope of restoration can be had. The others range upward through the moron group.

Any program approaching the problem of the mentally defective has immediately before it for consideration this question: Shall the training schools be devoted to the care and training of the higher-grade group among the mentally defective for whom some help in restoration should be expected, or shall the training schools be used for the reception of candidates taken from the waiting list without selection, not restricting the admission of those for whom no hope of restoration may be entertained, but who are a serious burden on the home and the community.

Up to this time the state has given consideration only to the latter procedure and it is to be questioned whether public opinion or the exigencies of the waiting list will now permit a change.

It appears probable that even with the highest development of the state's existing training school facilities, there must remain a school population having but a relatively small percentage of its number to whom the training facilities of the schools may be advantageously employed in restoration to acceptable community residence.

The problem before the state lies in the control of the 90 per cent of the mentally defective and epileptic population for whom no training school and hospital facilities are available. Such a problem can be met only by its intelligent consideration by a central state authority having supervision of the feeble-minded over the entire state, with its sequence of registration, public schools, special classes and mental clinics. The development of such a program as that indicated lies within the functions of the Council on Mental Health, as recommended by this Commission.

THE COUNCIL ON MENTAL HEALTH

Historians have noted an early reluctance on the part of Connecticut to provide tax-supported institutions for the care of the insane and mentally deficient. The state has within its borders one of the first hospitals of this kind to be founded in the country but it was conceived in the courage of private citizens and financed by their generosity. This institution opened its doors in 1824 and for many years took care of the few state patients that its limited accommodations would allow for two dollars a week. More than thirty years of legislative debate passed before the state opened its own hospital for the care of the insane which was located at Middletown in 1866.

During the past forty years this earlier lack of interest has been largely dispelled, but the development of the public facilities for the care of these people has been a series of episodes rather than orderly progress.

The absence of orderliness and coordination may, in part, be attributed to the custom of appointing a separate board of citizens to erect and administer each institution. This procedure is basically democratic and may have had some value in stimulating wider public interest in the institutions, but that it hindered the development of a progressive, state-wide program is scarcely to be denied. In this connection it is interesting to note the policy of the state in its care of the tuberculous. From the very beginning in the early part of this century, this entire program has been projected and carried out by a single small commission. The commission now operates five sanatoria which are closely correlated and have uniform policies and standards and a central statistical and admitting office. On the other hand the state also maintains five institutions for the care of the mentally sick and the feeble-minded and these hospitals are managed by five separate boards of trustees consisting of fifty persons. This type of administration has resulted in an absence of cooperative effort essential for successful attack upon the problem of mental sickness as a whole.

This lack of coordination was evidently realized by the General Assembly of 1939 when it authorized a joint board from the three hospitals for the insane to establish districts from which patients might be received. Further efforts at cooperation have been accomplished by the creation of a voluntary committee from the boards of the three hospitals for the insane at the suggestion of the Governor and a central classification and admitting office has been voluntarily created from the two schools for mental defectives.

Connecticut is one of eight states that do not have some type of central organization to coordinate their programs in the care and prevention of mental disease. Most of these states are decidedly small in population and some of them have only one or two institutions; only two of them are comparable to Connecticut and both of these are in the South.

This Commission is convinced that the time has come when the public interest will be better served if an agency of government is established to integrate and supervise the state's various activities in the care and prevention of mental disease. To accomplish this the Commission recommends the creation of a Council on Mental Health. In constituting the Council as provided in the proposed statute, care has been taken to maintain the democratic principle by continuing the several boards of trustees in the belief that local boards have an important role to play even though a strong central board exists. The Council will consist of one member each of the five boards, and it is believed that by this contact with the whole problem of mental disease in the state the importance and responsibilities of the boards of trustees will be increased. The Commissioner of Health is included among the members of the Council in order that the program in mental hygiene may be coordinated with the institutional activities and may supplement the out-patient and clinical work that the Council should initiate. The Commissioner of Welfare is on the Council so that ready advice may be had from him with respect to commitment procedure, financial responsibility and other phases of the program that are lodged in his department. A psychiatrist and a physician skilled in clinical medicine are included to provide expert counsel in the important medical aspects of the Council's progress.

The schools for the feebleminded were included in the plan and organization of the Council on Mental Health after careful consideration. This Commission is not unmindful that a large part of the care of these persons is a special educational function. However, it is of the opinion that the problem is so closely related to other forms of mental incapacity, especially as it may be encountered outside of the institutions, that the two are inseparable.

In making this recommendation for the establishment of an advisory and integrating central authority, the functions of which are set down in detail in the proposed statute, there is no intent to stifle the initiative of the boards of trustees or the superintendents of individual institutions or to disturb their autonomy. On the contrary, it is believed that by the unification of this initiative and the coordination of its application, the institutions will jointly contribute to greater public usefulness.

AN ACT CREATING A COUNCIL ON MENTAL HEALTH

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. COUNCIL ON MENTAL HEALTH. There is established a Council on Mental Health consisting of the Commissioner of Health and the Commissioner of Welfare who shall serve ex officio; one member of the Board of Trustees of each of the following institutions: Connecticut State Hospital, Norwich State Hospital, Fairfield State Hospital, Mansfield State Training School and the Southbury State Training School, and two physicians licensed to practice medicine in Connecticut who are not employed by the state or upon the staff of any institution wholly maintained by the state, one of whom shall be a recognized specialist in the field of psychiatry and one of whom shall have had not less than ten years of experience in the field of internal medicine. During the regular session of the General Assembly of 1941 and biennially thereafter, the Governor shall appoint one member from the Board of Trustees of each of said five institutions to serve for two years. During said session of 1941 the Governor shall appoint said physician who is a recognized specialist in the field of psychiatry to serve for two years, and during the regular session of the General Assembly of 1943 and quadrennially thereafter, the Governor shall appoint said physician to serve for a term of four years. During the regular session of the General Assembly of 1941 and quadrennially thereafter, the Governor shall appoint said physician who has had not less than ten years' experience in the field of internal medicine to serve for a term of four years. Each such appointee shall hold office from the 1st day of July next succeeding his appointment and until his successor shall be appointed and shall have qualified. The Governor may remove any of the members of said Council for cause. Any vacancy shall be filled by the Governor by appointment for the unexpired portion of the term. Said members of the Council shall be paid their actual and necessary expenses incurred in the performance of official duties. The Council shall elect its own chairman, shall have an office in Hartford where its records, papers and books shall be preserved, and shall meet at least once in two months and at such other times as the chairman may direct. Five members shall constitute a quorum.

Section 2. DIRECTOR OF MENTAL HEALTH. The Council on Mental Health shall employ in the classified service a full-time Director of Mental Health who shall be licensed to practice medicine in the State of Connecticut or eligible for such license, with experience in psychiatry and hospital administration. With the approval of the Governor and the Commissioner of Finance and Control, the Council shall fix the compensation for the Director and such other clerical and technical assistants as may be required.

Section 3. POWERS AND DUTIES OF THE COUNCIL ON MENTAL HEALTH. The Council on Mental Health shall direct and coordinate the activities and objectives of the institutions concerned with the public care of the mentally sick, mentally defective, epileptic and inebriate; shall study the needs of the state and initiate and direct programs of prevention and follow-up activities outside of the institutions and direct the development and coordination of services that will improve mental health in the state and decrease admissions and re-admissions to institutions; shall standardize, coordinate and maintain statistical records for the institutions; shall receive and review the biennial budgets for the institutions and submit them with recommendations to the Budget Director; shall establish districts from which mentally ill or mentally deficient persons in need of state hospital care shall be admitted or committed to each of said hospitals; shall make rules and regulations with respect to the transfer of patients between state institutions for the care and treatment of the mentally sick, mentally defective and epileptic and also with respect to the transfer between these institutions and other institutions; shall establish standards, investigate and issue licenses for institutions for the treatment or detention of insane persons or persons suffering from abnormal mental or nervous conditions; shall establish standards for, and provide and maintain a list of qualified examiners in psychiatry; shall consider continuously the needs of the state in the field of mental illness and recommend desirable legislation pertaining thereto, and shall transmit biennially a report of its activities and recommendations to the Governor.

Section 4. Section 572e of the 1939 Supplement to the General Statutes is hereby repealed.

AN ACT AMENDING AN ACT CONCERNING THE LICENSING OF INSTITUTIONS FOR THE CARE OF THE INSANE

Section 682c is amended to read: (new material set in heavy type)

Section 682c. LICENSING OF INSTITUTIONS FOR THE CARE OF THE INSANE. No person, firm or corporation shall conduct or maintain within this state an institution for the treatment or detention of insane persons, or of persons suffering from other abnormal nervous or mental conditions, unless such persons, firm or corporation shall, upon written application, verified by oath, have obtained a license therefor from the State **Council on Mental Health.** Said **Council** shall prescribe reasonable **standards** for such institutions. After receiving an application and making such investigation as shall be deemed necessary and after finding the specified requirements to have been fulfilled,

said **Council** shall grant a license to such applicant to conduct an institution of the character described in such application, which license shall specify the location of such institution and the name of the person to have charge thereof. Any person, firm or corporation aggrieved by any requirement of said **standards** or by the refusal to grant any license may, within twenty days of any order directing the enforcement of any provision of such **standards** or the refusal of such license, appeal to the Superior Court in the county in which such institution is located or to a judge thereof, if said court shall be in vacation. Each such institution shall be in charge of a physician registered under the laws of this state who has had at least three years' experience as a full-time medical attendant in some institution for the care and treatment of insane persons or of persons suffering from other abnormal nervous or mental conditions. If the licensee of any such institution shall desire to place in charge thereof a person other than the one specified in the license, application shall be made to the State **Council on Mental Health** in the same manner as provided for the original application, for provision to make such a change, which application shall be acted upon within ten days from the date of the filing of the same. Each license granted under such Section shall provide that any person under treatment or detention by the licensee shall be entitled to all the rights to which a patient in an asylum is entitled under the provisions of Sections 1760 and 1761, and all such persons shall be informed of their rights under said Sections by the licensee in such manner as said **Council** may prescribe. Each such license shall terminate on the 31st day of December of each year and may be revoked by the State **Council on Mental Health** upon proof that the institution for which such license was issued is being improperly conducted or for the violation of any provisions of this Section, or of the **standards established by said Council,** provided the licensee shall first be given a reasonable opportunity to be heard in reference to such proposed revocation. Any person, firm or corporation aggrieved by such revocation may appeal to the Superior Court in the same manner as hereinbefore provided. Each person, firm or corporation, upon filing an application under the provisions of this Section, shall pay to the State Treasurer the sum of $50.00. Any person, firm or corporation who shall conduct any institution contrary to the provisions of this Section shall be fined not more that $1000.00 or imprisoned not more than six months or both. Nothing in this Section shall be construed to change the duties or authority of the Public Welfare Council under the provisions of Section 713c.

THE COMMITMENT OF INSANE PERSONS

The emergency commitment statute so-called (Section 1732 of the General Statutes, Revision of 1930) was designed to effect, in the interest of the patient, his family and the public, the commitment of persons in immediate need of emergency treatment. The language therein employed, however, contemplates the commitment of persons who have become suddenly and violently insane. Persons who by reason of their mental condition may be dangerous to themselves and to others and therefore in need of immediate confinement are in many cases neither violent nor has their condition been one of sudden acquisition. Consequently, a strict construction of the statute may result in tragedy. On the other hand, persons suffering from a mild senile psychosis and whose immediate confinement is therefore not essential may be thought to fall within its provisions. Thus the statute does not serve its purpose. As amended, however, it provides for the commitment on the certificate of one physician only in that case where the patient is dangerous to himself or to others. In all other cases where treatment is indicated, his commitment may be affected only on the certificate of two physicians.

The Commission finds that no form of certificate for emergency admission has ever been legally prescribed. For the protection of the patient and the committing physician, and in the interest of uniformity, a form should be established. Because the Commissioner of Welfare and the superintendents of the state hospitals are best qualified to pass on the efficacy of such a form, the statute as amended requires the adoption of one which shall have their approval. It further provides for the execution of the certificate in duplicate, one copy to be delivered to the state hospital as is now contemplated—the other to be filed in the probate court of residence.

Under the present statute, upon emergency commitment the physician in charge of a state hospital must notify immediately the Commissioner of Welfare in order that proceedings for permanent commitment may be instituted. In some cases the action taken by the Commissioner results in commitment, in others it does not. But in the greater number of cases an expense to the patient or his family is incurred by reason of the additional medical testimony necessitated and certain legal fees incident thereto, an expense which in a very substantial number of the cases ultimately falls upon the state.

The statute as amended permits discharge during the temporary period when treatment is not required, and in such cases requires notification thereof to the Commissioner of Welfare in order that

further proceedings may terminate forthwith. Where, however, the necessity for continued treatment is apparent, the probate court must appoint from an approved list a qualified examiner whose fees are to be paid by the state, thereby eliminating the patient's expenses and assuring an examination by one expertly qualified in matters of mental illness.

The Commission believes that the amended statute affords protection to mentally ill persons in addition to that heretofore existing, that it insures great caution in the matter of emergency commitment, that it permits discharge in cases warranted without undue formality, that it eliminates certain unnecessary expense, that in those cases where continued treatment is required, it provides a closer relationship with the probate court of residence, and that it conforms to modern psychiatric knowledge and practice.

AN ACT CONCERNING THE ADMISSION OF INSANE PERSONS TO HOSPITALS ON CERTIFICATE

Section 1732 of the General Statutes as amended by Section 676c of the Supplement entitled "Detention of Violently Insane Persons" is amended as follows:

NOTE: Matter set in heavy type is new law added. Asterisks indicate old law omitted.

Section 1732. ***ADMISSION OF INSANE PERSONS TO HOSPITALS ON CERTIFICATE. Any person *** in need of care and treatment in a hospital for the insane, **including any person mentally disturbed by reason of the use of drugs, alcohol or other poisons,** may be admitted to and confined in such hospital, either public or private, **for not more than *** forty days** without order of any court *** **on receipt** of a certificate signed and sworn to by *** **two physicians licensed to practice medicine in Connecticut, provided, however, that any person who is dangerous to himself or to others may be admitted to and confined in such hospital for such period without order of any court on receipt of a certificate signed and sworn to by one physician licensed to practice medicine in Connecticut. *** Said certificate shall be on a form prepared by the Department of Welfare, approved by the superintendents of the state hospitals for the insane and the Attorney-General, and shall set forth in detail the reasons necessitating admission. Said certificate shall establish that a personal examination of such person has been made by said physicians or physician, as the case may be, within three days of its receipt and shall be executed in duplicate, one copy of which shall be filed in the hospital of admission at the time of admission and one copy with the judge of probate in the district of the patient's residence within twenty-four hours of such admission.**

When any person shall be admitted to and confined in a state hospital pursuant to the foregoing, the doctor in charge thereof shall immediately upon the delivery of such person to such hospital notify the Commission of Welfare in writing, who shall cause proceedings to be instituted for the commitment of such person in the court of probate having jurisdiction in the town where such hospital is located, and in case such person shall be committed upon the application of the Commissioner of Welfare, he shall collect from the towns in which such person has a settlement or from such person or persons as may be liable for his support the amount expended for such commitment and for the support and benefit of such person in the manner provided in Sections 1733, 1745 and 1747. **Prior to the expiration of said period of forty days, the doctor in charge of any state hospital may discharge such patient if in his opinion such patient is no longer in need of the care, treatment and custody provided, and in such event he shall forthwith notify the Commissioner of Welfare in respect thereof. If in the opinion of said doctor in charge such person is in need of further care in the institution, he shall so notify the court of probate having jurisdiction in the town where such hospital is located, and the judge of said court shall thereupon designate a physician duly licensed to practice medicine in this state who shall be on an approved list of examiners in psychiatry to visit the patient at the hospital, to consult the patient's record and to examine him, and said examiner shall file a report with the judge of probate for his guidance and shall receive from the State of Connecticut a fixed fee of ten dollars and five cents per mile for travel from his residence to the hospital and return. Thereafter and within said forty day period said court of probate shall hold a hearing and if the court shall find such person to be in need of care and treatment in such hospital or that he should be confined therein shall make an order for his commitment thereto to be confined while such condition shall continue or until he shall be discharged in due course of the law.** ***

THE CARE OF THE CHRONICALLY SICK AND DISABLED

There is in Connecticut, as there is throughout the United States, a continually increasing proportion of the people who have reached the age of sixty years. There is ample evidence to support this statement. Furthermore, studies by this Commission of certain state institutions reveal a considerable increase in the percentage of admissions within this age group. Among this group is to be found sickness and disability incident to cancer, chronic heart disease, chronic arthritis, chronic disease of the blood vessels and diseases of degeneration in their many forms. There is evident an increasing proportion of those persons to the general population particularly susceptible to these diseases which are in fact diseases of advancing years.

The increase in number and proportion of those over sixty years of age is not correlated, however, with any increase in their financial resources. With this increase in longevity appears, on the other hand, an increase in their reliance upon the resources of others to carry them through the years and provide for their care when sick or disabled. Even for those who have been provident and have made efforts to care for their future, chronic illness with its attendant costs of even minimum care and medical service may make such demands upon their resources that the savings of a lifetime are exhausted and a continuation of these necessary services made dependent upon assistance from relatives, the town or the state.

There is no statistical evidence available that will permit any reasonably accurate statement of the costs to the state of those people who are sixty years or more of age who have, through state funds, received hospital and medical care because of chronic illness. There is, however, the indisputable evidence of the relationship between economic status and sickness, and that two major elements in the problem presented by the chronically sick are poverty and advancing years. Social workers have found that ill health is the chief cause for charitable relief and it is probably the greatest single factor causing dependency of the aged.

This Commission held a conference at the Capitol in Hartford to consider all aspects of medical care, to which social workers, hospital authorities and relief administrators were invited. This conference was attended by representatives of seventy social organizations who were asked to present their opinions in respect to the greatest needs of the state in the medical care of its people. Attention centered upon the need for better and more readily available medical care for the chronically ill. There was unanimous opinion among those present that

there now exists a material lack in the facilities for medical and hospital care of those sick or disabled by chronic illness. Hospital authorities stated that with the demands made upon their institutions for the care of acute illness, satisfactory provision cannot now be made for the chronically ill.

In 43 towns, almshouses are maintained for the care of the poor, the aged and the sick. The report of the Public Welfare Council for 1939 notes 2,580 persons resident in these almshouses. Many are not equipped to cope with the problems of illness, yet ill health in many instances is the major cause of poverty which in turn is the cause for keeping the almshouses open. It is probable that too many communities are content with supplying food, shelter and clothing, and that adequate medical care is lacking. Because many of the almshouses are what they are, the Public Welfare Council and its predecessor, the Department of Public Welfare, have recommended to the General Assembly that a state infirmary be established for the care and treatment of aged and infirm persons and the chronically sick, for whom proper care is not available in existing institutions.

The Commission to Investigate the Subject of Old Age Pensions reported in 1933 that, "The most serious defect in the town poor farm system is the general lack of adequate medical and nursing care. This lack is inevitable in those almshouses remote from hospitals and doctors. Unfortunately, the same lack is found in many larger almshouses located on good roads in or near populous centers." The Commission to Study the Pauper Laws reported in 1937 that, "A great many of the old people and not a few of the younger ones found in the almshouses were there because of illness. Some of these were bedridden and some were confined to wheelchairs."

The report of the Public Welfare Commission for the year ending June 30, 1939 states, "Visits made to the almshouses disclosed that many of the inmates were chronically ill and there were no hospital facilities in the almshouses in which they were lodged. For many years there has been need of a state infirmary to care for such cases, and the need still exists since the existing law in regard to old age assistance does not provide for these people."

The Secretary-Director of the Public Welfare Council stated to this Commission: "Most of the almshouses in the state are old buildings not designed for the purposes for which they are used and lacking in modern hospital equipment. Moreover, those in charge have had little or no training in the care of the sick. Our Inspector of Institutions has found a distressingly large number of aged cancer victims in almshouses where inadequate facilities for care existed, and we have been instrumental in securing care for these outside the state because there were no state or private hospitals in Connecticut to which these could be removed."

There are 240 boarding homes for the aged licensed by the Public Welfare Council. These homes are not designed nor is it intended that they should provide for the care of the chronically ill. It is probable, however, that more of this class are in these homes than should be there.

For those able to make payment for services, the facilities of some 200 chronic and convalescent hospitals are available. While the term "hospital" is applied to these facilities, the proper designation might better be chronic and convalescent nursing homes, for the facilities associated with general hospitals do not as a rule appear in these institutions. These hospitals or homes are under supervision by the State Department of Health, and an important requirement of this supervision is that the nursing service connected therewith shall be given by registered nurses or by trained attendants.

In addition to the facilities for the care of the aged and the chronically ill, there are 44 endowed or privately-supported homes for the aged in the state. These offer accommodations for about 2,000 persons. Residents in these homes under existing law cannot qualify for old age assistance. Admission to these homes is generally dependent upon religious or fraternal affiliation and financial ability to meet certain requirements. In most of these homes normal physical and mental health is a requirement for admission, and they contribute only in small measure to the care of the chronically sick or disabled.

Institutionalization of beneficiaries under the old age assistance law has presented a problem of considerable magnitude for the reason that the law does not permit payment of awards to persons living in institutions. The size of the problem is indicated by the fact that there is a steady increase in the number of beneficiaries, and it is reasonable to assume that comparably larger numbers will need to enter institutions because of illness.

The law concerning eligibility for old age assistance in Connecticut (Sec. 730c) provided originally that no person could receive an award who was "receiving institutional care at public or charitable expense," but that provision was changed to read, " . . . is not an inmate of an almshouse or other public or private institution." (Sec. 607e) In December, 1936 the Attorney-General ruled that private hospitals and homes operated for pecuniary gain are not included within the intended meaning of the act. The Bureau of Old Age Assistance reported in 1937 after conferences with the Attorney-General that "the difference between hospitals, homes for the aged, convalescent and boarding homes and state institutions was clearly marked."

Although it cannot be said that need for medical care was a factor in each case, it is noteworthy that according to the 1937 report of the Bureau of Old Age Assistance only 75 per cent of the beneficiaries were able to manage on their awards without outside help. However, the amount of many of the awards has been increased and the weekly maxi-

mum which may be paid to an old age assistance beneficiary is now $9.00. Medical care is an important factor in the situation and no doubt the records of the Bureau would disclose that many had applied for benefits because they had exhausted their resources in payment for chronic illness.

The Connecticut Commission to Investigate the Subject of Old Age Pensions reported in 1933 that the care provided for aged persons was generally insufficient, especially as to medical care and services. There is no evidence showing that this condition is materially different today than it was at that time.

There would be difficulty in obtaining, without a more extended survey than is either warranted or necessary, definite data concerning the number of persons chronically sick or disabled in Connecticut.

Certain facts, however, are evident and appreciable. The number of persons over sixty years of age and their number in proportion to the general population is increasing. The diseases to which they are particularly susceptible are also increasing, and cancer and heart disease constitute the two greatest causes of death in the state. The disabilities resulting from arthritis and degenerative diseases are a common picture to those in charge of hospitals, to social workers, to nursing organizations and to physicians. The most casual survey will reveal the entire absence of any direct provision yet made by the state for the care of the chronically ill and disabled. Within the towns there are a number of almshouses largely without adequate provision for the sick. Convalescent homes or hospitals offer some care for those able to pay. Homes for the aged offer little medical care. General hospitals are occupied with the care of the acutely ill and cannot give up their beds to those who must remain in the hospital as chronic patients.

The proposal that the state provide medical care for its charges who are not hazards to society, as is the case with those suffering from tuberculosis or mental diseases, brings a new concept of social responsibility. It is a proposal that should be thoroughly discussed and the actual extent of the need for it carefully investigated. It is to accomplish this that this Commission has recommended that a board be authorized to continue the exploration of this field and that board should include persons who are well informed in the medical and social problems of the chronically ill and representatives of the interested public. Among the technical matters that need consideration are: (a) extent of the facilities that will be required to meet the problem; (b) the desirability of utilizing sections of general hospitals and clinics for the care of the chronically ill; (c) the size of units which will be efficient and economic for an institution; (d) the physical and financial association or affiliation of chronic institutions with general hospitals; (e) obtaining an organization of adequate medical and nursing and social service staff; (f) satisfactory forms of construction and equipment; (g)

formulation of desirable policies with respect to the types of diseases and categories of persons to be admitted or excluded and the determination of the public agency that will be charged with the process of admission and financial administration.

AN ACT CREATING A COMMISSION ON THE CARE OF THE CHRONICALLY SICK AND INFIRM

Be it enacted by the Senate and House of Representatives in General Assembly convened:

There is created a Commission on the Care of the Chronically Sick and Infirm. Said Commission shall consist of five citizens of the state and shall include persons who are informed in the medical and economic problems of the chronically sick and infirm, to be appointed by the Governor on or before the 1st day of July, 1941 and to hold office until Jauary 1, 1943. The members of said Commission shall receive no compensation for their services but their necessary expenses shall be paid by the state upon certification by the Chairman; and with the approval of the Governor and the Commissioner of Finance and Control said Commission may employ and fix compensation of such clerical and other assistants as it may, from time to time, require and appoint.

The Commission shall study the extent of the needs for the care of the chronically ill in this state and formulate policies with respect to the type of disease and the persons for whom such care shall be provided, and shall determine the public agency that will be charged with the responsibility for the administration of such facilities as may be found necessary to provide this care.

The Commission shall report its findings and its recommendations to the Governor on or before January 1, 1943 and shall embody in such report drafts for legislation necessary to carry its recommendations into effect.

STATE AID TO GENERAL HOSPITALS

For many years, payment by the state to general hospitals has taken two forms: one, annual grants; two, a weekly rate for the care of state charges. Historically, the annual grants voted by the General Assembly have been for the general purpose of sustaining the hospitals for the benefit of all the citizens of the state and, until recent years, held no relationship to the care of the state welfare cases. The amount of grants have been roughly proportional to the size of the community, but there has been no formula for the determination of the amount.

Payment for services rendered in caring for the state welfare cases was established many years ago at $4.00 per week. The General Assembly in 1937 increased this to $8.00 per week. Before the depression, this dual system in general worked well and paid its way. But in the last twelve years, the care of state welfare patients in general hospitals has increased from 18,749 days to 86,570 days or 360 per cent. Total payments to hospitals in the same period have increased from $321,964 to $415,433 (1939), an increase of only 29 per cent. From the records of the State Department of Public Welfare it is apparent that eleven of the thirty-three hospitals render 74 per cent of the total care but receive only 54 per cent of total payments. All of these hospitals on a proper accounting basis have an actual cost of caring for ward patients, including board and care and extra services, in excess of $5.00 per day. On the basis of a cost of $5.00 per day, these eleven hospitals suffered a total loss of approximately $94,000 in the care of state welfare patients in the fiscal year ending June 30, 1939. In the individual hospital, losses varied from $66 to $37,800.

Added to this is an even larger loss in the care of town cases and a lesser loss in the care of automobile accident cases. Coupled with a diminishing yield from endowment funds and decreasing donations and bequests from the public, the amount of free and below cost treatment rendered by these hospitals presents a serious problem.

It is entirely foreign to general policy for the State of Connecticut to receive charity from a charitable institution. That is precisely what is happening in connection with hospitals mentioned above. Therefore, it is recommended that proper steps be taken to correct the difficulty.

AN ACT AMENDING AN ACT CONCERNING APPROPRIATIONS TO HOSPITALS AND HOSPITAL RATES

Section 90d of the 1937 Cumulative Supplement is amended to read as follows: (New material set in heavy type)

"APPROPRIATIONS TO HOSPITALS. All appropriations to hospitals by the General Assembly shall be expended under the direction of the governor and of the managers of such institutions, respectively, for the support of charity patients, and so used as to benefit the state as application may be made from time to time, a report of which expenditure shall be made biennially to the General Assembly: but no part of such appropriations shall be paid to any of such hospitals unless the same be in actual operation, unless the purpose for which an appropriation is to be expended is for a building and is so specified in the act making such appropriation. No such hospital shall charge or receive more than eight dollars per week for the care of any patient when such expense is to be paid by the state, either directly or through the agency of any town therein, **provided, however, that if the total of the expense incurred by the state for such care during any fiscal period at said rate of eight dollars per week plus the annual appropriation by the General Assembly to such hospital shall not be sufficient to pay such hospital for such care at the rate of five dollars per day for each such patient, such hospital shall be paid the deficiency by the state within ninety days after the close of said fiscal period.**"

PROVISIONS FOR THE MENTALLY ILL WHO ARE IN NEED ONLY OF CUSTODIAL CARE

There were in the state mental hospitals of Connecticut on June 30, 1940 7,532 patient inmates. Of those, 5,829 or 77.3 per cent were stated to be in such mental and physical condition that their recovery was improbable. Among this number were hundreds whose needs for the services of a mental hospital had passed and whose only necessities were those of custodial care, nursing service and such medical attention as might from time to time be required by their physical ailments.

These people are, as a rule, advanced in years. Their hospital residence has been long. Their relatives and friends may have disappeared, and their only opportunity for care is to be found in the institution to which they were committed for their mental illness. They are not unruly nor do they require restraint. They constitute a group whose chief needs are kindly and humane custodial care. To this care they are entitled and this care they have received.

The records of the state mental hospitals disclose, however, an overcrowding that has been prejudicial to the proper care of that class of inmates for whom recovery might be anticipated. The provision of additional facilities at Newtown should for a time serve to relieve this condition of overcrowding. If the yearly number of admissions to these hospitals continues for the next ten years at the level of the last decade, the picture presented by overcrowded mental hospitals will again have to be faced. If new construction is to be avoided at the end of or within this period, it is essential that among other measures to be taken should be one concerned with the care outside the hospitals of those for whom the facilities of a mental hospital are no longer necessary.

In Massachusetts and New York provisions have been instituted for the boarding out of mental patients whose mental and physical condition is suitable for such separation from the hospital. It is not clear with what measure of success these provisions have been employed or that their costs have been less than that of institutional service. It is possible that such a plan might be employed in Connecticut, but there is no assurance that it would be successful. In any event, it would be a matter of experiment and its chief value, if successful, would be in reducing the need for capital expenditure for institutional provisions for the care of those boarded out.

This Commission has recommended that the provisions for the state care of the deaf be centered at the American School for the Deaf at Hartford, and the reasons supporting this recommendation are set forth

in this report. If these recommendations are carried out, accommodations for from four to five hundred custodial care cases would become available at the present Mystic Oral School. The cost of maintenance of these patients should be no greater than that of the institution from which they had been transferred. The hospitals, relieved of the necessity of their care, could utilize the space and services thus vacated for the care of those with acute mental illnesses for whom hope of recovery might be anticipated. The use of the institution at Mystic for this purpose would serve for a time at least as a buffer to over-crowding of the existing hospitals. Together with other measures that have been suggested for the Council on Mental Health, this step would for some time delay the demand for additional institutional facilities for the care of the mentally ill.

AN ACT CREATING A CUSTODIAL CARE INSTITUTION AT MYSTIC UNDER THE ADMINISTRATION OF THE NORWICH STATE HOSPITAL

Be it enacted by the Senate and House of Representatives in General Assembly convened:

The properties, plant, buildings and equipment now occupied by the Mystic Oral School at Groton shall become a part of the Norwich State Hospital, and shall be maintained and operated as an institution for patients transferred thereto from the state hospitals for the insane who are no longer in need of other than custodial care.

THE CARE AND PREVENTION OF TUBERCULOSIS

The story of Tuberculosis in Connecticut for the last forty years is that of a disease which in the year 1900 lead all others as a cause of death among the people of the state, but which in the year 1939 was found responsible for a fewer number of deaths than any other major cause.

The following table shows the number of deaths from tuberculosis, all forms, for each five year period, 1900-1939, and the death rate for each of these periods for each 100,000 of the population.

	Five Year Periods							
	1900–1904	*1905–1909*	*1910–1914*	*1915–1919*	*1920–1924*	*1925–1929*	*1930–1934*	*1935–1939*
Average Deaths	1600	1652	1686	1874	1380	1100	828	650
Deaths per 100,000 population	171	162	146	139	96	70	50	37

For the tremendous decrease thus shown in the destructive force of this disease, there should appear to be reasons showing a distinct relationship between cause and effect, but these relationships are not easy to assign. Tuberculosis is a disease associated with overcrowding, unsanitary habitations, long hours of labor, poverty and all those conditions that predispose to a lowered resistance on the part of the individual, as well as to close contact between individuals and the ensuing opportunity for the transfer of the infective organism of the disease from one person to another.

In the years that have passed since 1900 many of those factors that predisposed toward tuberculosis have either disappeared or are in process of correction, while other helpful factors have appeared. The restriction of immigration has resulted in the development in Connecticut of a relatively stable population. The processes of education in the public schools have instilled in our future citizens the principles of personal hygiene, while special education directed toward the prevention of tuberculosis has been provided over the years by private organizations. Laws relating to the age at which young persons may enter industry have been enacted; the hours of labor of all industrial workers have been regulated; the conditions under which labor is carried on have been made subject to inspection and investigation by state authority, and the industrial hazards of employment have been scrutinized. There is a trend toward participation in outdoor sports by the younger people of both sexes, and habits of dress have improved. Perhaps another factor of importance is the trend of the population away from the cities into the country. While the cities remain the centers of industrial activity, the workers in them are continually seeking their

residence in small communities easily reached over good roads by automobile transportation. All standards of living have greatly improved in the last forty years and the luxuries of the year 1900 are commonplace today. Perhaps the greatest of these has been the transition of large groups of the population from the crowded quarters of city living to the open air surroundings of country residence. If statistics were available there might well appear a reasonably constant relationship between the decentralization of our urban population and the decrease shown in the deaths from tuberculosis.

From the standpoint of public health control, tuberculosis is a disease that, when recognized, must be reported to the health officer of the community. On receiving such a report it is the health officer's duty to see that the person ill shall be properly cared for, that those who have been in contact with the patient shall be examined as to their physical condition, and that all measures shall be taken to prevent the spread of the disease from the person afflicted. If state sanatorium care for the person ill is necessary, it will be provided.

Among the weapons to be applied if tuberculosis is to be subjugated are institutions to which those ill with the disease may be removed and the chances for their recovery hastened through the resources of proper care and treatment there available. By the same procedure these persons will have been separated from the community as active agents of infection to others. Among all the states Connecticut stands among the first in providing state funds for the care of the tuberculous.

The history of sanatorium provisions for the care of the tuberculous in Connecticut begins with the report of a commission appointed by Governor Woodruff, 1907-1909, to advise the legislature as to the measures it ought to take to stamp out tuberculosis in the state. At that time over 1,600 persons were dying yearly from the disease and its death rate was over 160 for each 100,000 of the population. Following the report of this commission, the legislature of 1909 (Chap. 120) directed that three county homes for the tuberculous be constructed as soon as possible after the law became effective. (July 1,1909) It seemed desirable to the board of directors approved under the law that these homes be erected in the three largest counties of the state. The report of the board (September 30, 1910) notes the construction of such homes in New Haven, Hartford and New London counties, and that these homes were open for the reception of patients at that time.

The town of Meriden gave the state a tract of land of about nine acres with several buildings thereon which had formerly been used as an almshouse. It was then occupied by the Undercliff Association, a charitable organization in Meriden. The Undercliff Association made a gift of all of its personal property to the State of Connecticut. The state took over the property on January 1, 1910 and assumed the care and treatment of the patients then at the sanatorium.

The "home" in Hartford County acquired twenty-nine acres of land on Cedar Mountain. The land lay in the towns of Wethersfield and Newington and here were erected buildings designed to accommodate 113 persons, but were not occupied in September, 1910.

The location for Fairfield County was found in a seventy-five acre tract in the Borough of Shelton, in the Town of Huntington. The reconstruction and additions to buildings already existing on the property at the time of purchase provided at the end of the fiscal year 1910 for occupancy by fifteen patients.

The report of the board of directors for county homes for tuberculosis for the year ending 1920 recommended the construction of such homes in Middlesex and New London counties.

This board in its report ending September 30, 1912 notes the purchase of the "Post Farm" in Norwich with buildings under construction designed to care for 96 patients. This institution opened February 13, 1913 with 41 patients. Because the Meriden Sanatorium had many empty beds, more than enough to accommodate all the patients that Middlesex County was likely to send for some time to come, the idea of constructing a sanatorium in that (Middlesex) county was formally abandoned by the board of directors. The board at that time made clear its purpose to discontinue the identification of the sanatoria as "county homes" and to term them "state sanatoria." Since that time the sanatoria have been designated by the name of the county in which they are located or by local designations such as Cedarcrest, Laurel Heights, Uncas-on-Thames, Undercliff or Seaside.

With an appropriation of $25,000 made by the legislature of 1915 the Commission purchased the so-called White Beach Hotel property in Niantic, a building of thirty rooms and two acres of land and some outbuildings, for the care of children afflicted with bone and glandular tuberculosis. Attempts to enlarge this institution met with material opposition by neighboring property owners. The attempt to enlarge Seaside was abandoned when shore-front property at Waterford became available. Appropriation was made by the legislature for the acquisition of this property and the erection of buildings thereon, and in 1935 the institution at this location (Seaside) was occupied as a state sanatorium for the care of children with bone and glandular tuberculosis.

Connecticut maintains state sanatoria for the care and treatment of the tuberculous advantageously situated at Laurel Heights in Shelton, at Cedarcrest in Hartford, at Undercliff in Meriden, at Uncas-on-Thames in Norwich and at The Seaside in Waterford.

The first four of these sanatoria are maintained for the adult tuberculous; the sanatorium at Waterford is for the treatment of bone and glandular tuberculosis usually associated with childhood.

The capacity of these sanatoria is given below:

Sanatorium	*Location*	*Capacity*
Cedarcrest	Hartford	350
Laurel Heights	Shelton	382
Uncas-on-Thames	Norwich	428
Undercliff	Meriden	326
The Seaside	Waterford	143

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Associated with and available to all these institutions is the surgical unit maintained for the surgical treatment of tuberculosis.

The sanatoria are under the direction of the State Tuberculosis Commission, consisting of five members, "one of which shall be a physician who has had at least ten years' active practice and is an expert in the modern treatment of human tuberculosis."

The number of beds needed in a state for the care of the tuberculous may be based on the fact that there are on the average ten active cases of tuberculosis for each death recorded from this disease, and that of these ten active cases one-fourth will need institutional care.

Applying this formula to Connecticut, in which during 1938 616 deaths were recorded, we would have within the state 6,160 active cases of tuberculosis for whom 1,540 beds should be provided in accordance with the minimum of accepted standards. As a matter of fact there were within the state in that year 1,676 beds available for the care of the tuberculous. In the year 1938 Connecticut had the greatest number (five) of state sanatoria for the treatment of tuberculosis among all the states. Maryland, Massachusetts and New York each had four, Pennsylvania and West Virginia three each, and the others less than three. With the desirable number of beds for the care of the tuberculous set at two for each death registered, the following states provided for at least this number. All other states had less than two beds for each death.

Hospital Beds and Deaths from Tuberculosis

State	*Deaths 1937*	*Beds 1938*	*Number of Beds per Death*
Colorado	738	2613	3.50
Minnesota	911	2579	2.83
North Dakota	179	506	2.82
Connecticut	658	1676	2.54
Massachusetts	1908	4768	2.49
Wisconsin	1037	2538	2.40
Michigan	2137	3035	2.35
Rhode Island	319	728	2.28
New Mexico	535	1162	2.10
Maine	287	574	2.00

This Commission has made a careful survey of all financial and medical records of the state sanatoria from the time of their inception to the present. From this survey it appears:

(a) That the cost of care of patients in the sanatoria compares favorably with the states of Massachusetts and New York in which comparable standards of administration and care are known to be maintained.

State	*Year*	*Cost per diem*
New York	1938	$4.00
Massachusetts	1938	4.50
Connecticut	1938	2.91

(b) That the capacity of the sanatoria is such at this time that there is no waiting list to these institutions.

(c) That the administrations of these institutions provide for and maintain a high level of medical and professional care for the patients therein.

(d) That notwithstanding the outstanding facilities available at these sanatoria for the relief and cure of tuberculosis, these facilities are rendered relatively ineffective against the larger control of tuberculosis in the state, for the reason that the greater number of persons admitted to the sanatoria are afflicted with tuberculosis in an advanced or moderately advanced stage of the disease.

The following tabulation gives the condition on admission of all patients admitted to Cedarcrest, Laurel Heights and Uncas-on-Thames, by five year periods for the years 1911-1938.

It will be noted that over the years the percentage of patients admitted as incipent or minimal shows but little variation and remains at a low level; that the percentage of patients received as moderately advanced shows a material decrease, while the percentage of those admitted in a far-advanced stage shows a marked increase.

CONDITION OF PATIENTS ON ADMISSION TO CEDARCREST, LAUREL HEIGHTS, UNCAS-ON-THAMES

AVERAGE FOR FIVE YEAR PERIODS 1911-1938

	1911–1914		*1915–1919*		*1920–1924*		*1925–1929*		*1930–1934*		*1935–1938**	
Classified on admission as:	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Incipient	227	8.9	249	6.5	349	8.1	264	6.7	219	6.9	260	8.2
Moderately Advanced	893	35.1	1507	39.8	1648	38.2	1076	27.3	667	21.2	579	18.3
Far Advanced	1337	52.5	1766	47.0	2124	49.3	2348	59.6	1931	61.4	1975	62.7
Others	86	3.3	256	6.7	183	4.2	247	6.2	328	10.4	334	10.6
Total	2543	99.9	3778	100.0	4304	99.8	3935	99.8	3145	99.9	3148	99.8

Total of all admissions for period 20853

Classified as incipient	1568	7.9%
Classified as moderately advanced	6370	30.5
Classified as far advanced	11481	54.9
Others	1434	6.8
	20853	100.1%

*Four year period.

Connecticut now has and for a time will have adequate and well-maintained facilities for the sanatorium care of those of its people who are ill or who may become ill from tuberculosis.

The incidence of the disease has reached an all-time low level for the state and the record of deaths from this disease is now lower than for any period for which vital statistics have been recorded. The record of the state in tuberculosis compares favorably with the other states of the Union. Several factors are responsible for the results thus far obtained. Among these are the better standards of living among all of our people, the role of the sanatoria in the segregation of those ill and the restoration to health of many coming under their care, together with the extension of community health programs.

Continually and persistently throughout the years certain forces known to be effective in the control of tuberculosis have been in active operation under both state and private organizations. The forces have been and continue to be: the application of all known measures in the prevention of tuberculosis, the provision of adequate sanatorium facilities for those ill, the continuation of a health education program as it applies to tuberculosis, and measures designed to detect the presence of the disease in its earlier stages.

Notwithstanding this favorable experience, none of these measures may now be set aside. Assurance may be had perhaps that for some time the state will remain well equipped in its provisions for the care of those suffering from the disease, but there is no assurance that, unless measures of education and case-finding are continued and extended, such favorable experience will remain at its present level. The gains that have been attained must not be weakened by overconfidence.

It seems highly essential that the gains already made in the control of tuberculosis shall be consolidated and that there should continue in activity and under well-directed operation those forces up to this time so successfully employed, awaiting the day when research work now going on shall provide specific treatment in this disease. To determine how the state shall proceed not only to maintain the ground already gained in the control of tuberculosis but to gain more and more ground, there must be faced a fact that appears in clearly defined outline.

It is clear that while forces for some time in operation have resulted in a material lowering in the death rate from tuberculosis, it is equally clear from evidence at hand that present efforts are only partially successful in reaching those in the earlier stages of their disease.

Further progress in tuberculosis control in Connecticut will depend largely on an extension of the health education program and upon the effective extension of measures recently undertaken to bring the disease under treatment in its early stages. This Commission is con-

vinced that the activities above outlined should be directed by an agency equipped with all facilities for their successful completion. For the reason that a well-directed effort in this work has been made by the State Tuberculosis Commission, and because that Commission already possesses in part the facilities needed for it, the recommendation made in the first part of this report is advanced.

AN ACT AMENDING AN ACT CONCERNING THE TUBERCULOSIS COMMISSION

Section 2635, General Statutes 1930, shall be amended so as to read:

PREVENTION OF TUBERCULOSIS: The commission shall instruct the public in rules of living essential to the suppression of tuberculosis and shall provide and maintain within or apart from the state sanatoria facilities and personnel for the detection of tuberculosis in its early stages and for the rehabilitation of the tuberculous.

THE EDUCATION OF THE DEAF

The training of the deaf falls within the field of education and it becomes a health problem only as much as it is concerned with persons suffering from functional physical defects.

The problem of the education of the deaf in Connecticut should be a simple one were it not for the existence of certain complicating factors that are peculiar here. A commission to study the subject was authorized by Special Act 12, 1937, and although that commission apparently recognized the existing confusion, it made no concrete or comprehensive recommendations.

In comparison with other social and welfare problems in the state, the education of the deaf does not loom large, either in number of persons involved or the expenditure required. The state has a capital investment in physical plant to carry out the program of about $1,375,000 and expense of about $225,000 annually for maintenance. (1939-40, $214,689)

The philosophy underlying the program for the training of the deaf is based upon a broad application of the theory of education at public expense. The state undertakes to provide special educational advantages for children handicapped by deafness, and those advantages are given to such children in a manner identical with the provision of common education for children not so handicapped. As a matter of convenience and expediency deaf children are consolidated in boarding institutions, as is the accepted practice, and board and housing are provided for these children as well as education, so that they may be brought together in these special institutions.

There are two schools for education of the deaf in the state:

The American School for the Deaf in West Hartford is a privately-endowed institution that was chartered in 1816. It was the first school of this kind in America and for well over a century has enjoyed the highest reputation. The state has been generous with this school and it has borne the larger part of the burden of the state's responsibility for the education of the deaf. Part of the present plant of the school was built by state-appropriated funds, $250,000 by the General Assembly of 1919 and $250,000 by the General Assembly of 1921. The appropriation of 1919 is protected by an underlying lien on the property; the appropriation of 1921 is not so protected. During the years 1939-40 the American School provided instruction for 220 state-supported pupils and received a maintenance appropriation of $124,020. The American School has income from private endowment of about $15,000 per annum.

The Mystic Oral School at Mystic began as a private proprietary institution in the Town of Ledyard in 1869. It was later removed to Mystic and the school and its real estate was purchased by the state in 1921. Since that time it has been owned and entirely maintained by the State of Connecticut. The present plant, including the expenditure recently made for its extension, some of which was provided by federal grant, is valued at approximately $875,000. One hundred and five children were enrolled at the school at the beginning of the current academic year, and the 1940-41 budget allotment was $105,488.66.

During the period 1921-1939 inclusive, the American School for the Deaf was granted $1,711,825.69 for support. The average enrollment of pupils supported by the State of Connecticut during those nineteen years was 187. These children were maintained at a per capita cost of $481 per annum.

For the period 1921-1939 inclusive, expenditures for the support of the Mystic Oral School were $1,499,640.41. During that time the average enrollment was 80 pupils who were maintained at a cost of $987 per annum.

There are two general methods of instruction for the deaf and these two Connecticut schools employ them. The American School is what is known as a "combined" school and employs both lip reading and training in the manual or sign alphabet. The Mystic School is exclusively an "oral" school, that is, it relies entirely upon instruction in lip reading. The controversy concerning the merits of these two methods of instruction is by no means confined to the State of Connecticut, nor is it new. Each method has its ardent advocates and this Commission does not feel that it is competent to decide the issue. The Commission is, however, strongly of the opinion that the State of Connecticut is not interested in any sentimental attachment to a specific teaching method, but is concerned with an educational program that will provide the practical training for the deaf, especially in vocational fields, that will prepare this small group of children to become self-reliant citizens in a hearing world.

The development of any program of this nature should be carefully predicated upon an estimate of the potential demand. In several states provision is made for the education of one deaf child for each 10,000 of the gross population. A good working standard estimated by Volta Bureau (the national organization interested in the education of the deaf) is provision for one pupil for each 7,000 of the gross population. On this basis Connecticut should provide for about 250 pupils. At present there are about 305 state-supported pupils in the two schools. With the increase in facilities at Mystic that have lately been completed, there are accommodations for about 225 students in that school. If the enrollment at the American School continues at its present level (220) there will be available in the state provision for nearly 450 pupils.

which appears to this Commission to be far in excess of the expected demand. Unlike many other health and welfare needs, the problem of the deaf is not increasing. The enrollment in residential schools for the deaf throughout the United States has declined every year for the past six years and is now seven per cent less than it was in 1935. The average enrollment throughout the country is one pupil in a special school for the deaf for each 6,750 of the general population. Connecticut is no exception to the general trend, and it is apparent that the state has expanded its facilities for the training of these children beyond that which should be expected.

It is not to be denied that the buildings which have just now been replaced at the Mystic School were obsolete and fire hazardous, but the logic of their replacement with extended facilities, as was done, may well be questioned, and was not the result of any careful study of the problem or justified by the circumstances.

Admission of students to these schools depends upon appointment by the Governor under Sec. 1056 of the General Statutes, Revision of 1930.

In the opinion of this Commission the Governor is not alone qualified to determine the fitness of a prospective student for admission and such admission should depend upon a careful examination of the hearing status of each applicant, made by a competent otologist, and a determination as to whether the prospective pupil may be benefited by the educational program provided.

Careful inquiry has been made by this Commission as to the careers of graduates from both of these schools and their ability to take their places in society as self-supporting citizens. As a result of this study it appears to the Commission that the efforts of the American School in this connection have probably been more effective for the graduates of that school than for the graduates from Mystic. This is especially true because the American School, with its equipment, has been able to train pupils in shop practice, the assembling of intricate machines and other productive vocations.

The Commission is of the opinion that the facilities offered by the American School are sufficient in quantity and quality to answer the demands of the state for the education of the deaf, and that the school at Mystic be discontinued. To further this and bring the administration of the American School into closer relationship with its public purpose, it is recommended that the Commissioner of Education and the Commissioner of Finance and Control of the State of Connecticut become ex officio members of the board of directors of that school.

It is further recommended that all admissions to training in special schools for the deaf at public expense be made by the Commissioner of Education after proper examination and inquiry.

AN ACT ABOLISHING THE MYSTIC ORAL SCHOOL FOR THE DEAF

Be it enacted by the Senate and House of Representatives in General Assembly convened:

The Mystic Oral School for the Deaf maintained under the provisions of Chapter 57 of the General Statutes, Revision 1930, is abolished and Sections 1053, 1054 and 1055 are repealed.

AN ACT AMENDING THE CHARTER OF THE AMERICAN SCHOOL, AT HARTFORD, FOR THE DEAF

Be it enacted by the Senate and House of Representatives in General Assembly convened:

The governing board of the American School, at Hartford, for the Deaf shall include thereon the Commissioner of Education and the Commissioner of Finance and Control of the State of Connecticut ex officio.

AN ACT AMENDING AN ACT CONCERNING THE APPOINTMENT OF PUPILS TO SCHOOLS FOR THE DEAF

Section 1056 is amended to read: (New material set in heavy type)

The **Commissioner of Education** may appoint pupils. Support and care. Expense. **The Commissioner of Education after examination and inquiry may appoint** for a period of not more than twelve years, any deaf minor person, domiciled within this state, as a state-supported pupil at any institution in this state for the education of the deaf, and he may, upon the recommendation of the principal or superintendent of such institution, extend such period not exceeding six years. **The Commissioner of Education** may revoke such appointment. **The Commissioner of Education** may contract for the support, care and education of any person so appointed and no such appointees shall be withdrawn from any such institutions except with the consent of the authorities thereof or of **the Commissioner of Education.** The expense incurred for such support, care and education shall, while such persons continue as such pupils, except so far as such expense may be paid by such pupils or their parents or guardians, be borne by the state in such amounts as may be appropriated by the General Assembly per capita per annum.

THE CARE AND EDUCATION OF THE BLIND

The broad field of the state's relationship with the blind lies largely within the purview of the State Board of Education of the Blind. This Board was originally established in 1893 although the scope of its present work is due to powers and duties established for it by the legislature of 1921.

The name of this Board is perhaps a misnomer, for the educational fields participated in by the Board are a minor feature of its work. A name more nearly expressing the functions of the Board would be, The Bureau of Service to the Blind.

There are slightly more than 2,000 blind persons in Connecticut, about 65 per cent of whom are more than fifty years of age. A little more than 5 per cent of this number are cared for by the Connecticut Institute for the Blind, a private corporation operating two institutions; a school for blind boys and girls in Hartford where there are about 75 children in residence, and a trades department at Wethersfield where about 35 blind men and women are provided for. The Board of Education of the Blind pays the tuition of each blind child and adult who has received such care. The State of Connecticut appropriated money for the purchase of land upon which these buildings were erected and has liens against the property, but a private, self-perpetuating Board of Directors supervises the work of the Institute.

While the work of the Board with the not more than 6 per cent of the blind persons who are receiving educational and trades training opportunities is of importance, more than 94 per cent of the blind remain in their own homes, and it is to this group that the greater part of the work of the Board is directed. The Board has five home visitors who are blind, who are assisting, instructing, guiding and encouraging more than five hundred blind adults in their own homes; also five workers who function in the field largely with the adults; and one person who devotes most of her time to work for the blind and nearly blind school children, with special efforts for the pre-school children and their mothers. The Board also provides specialized relief for the blind and the prevention of blindness, and supplies and materials for home industries which enable more than 300 persons who live in their own homes to fashion useful articles to be sold by the Board, the full price secured for an article being allocated to the blind person. In recent years the Board has served annually, in some way that has involved the expenditure of money or of personal service, about 1,400 blind people, more than 200 individuals with defective vision, mostly school children, and more than 125 persons, mostly adults, who are classified as "not blind" who have seriously impaired vision.

There are Aid to the Blind benefits provided in Connecticut from state and federal funds, for needy blind persons up to a maximum of $9.00 per week. These benefits are available on the same terms which are open to candidates for old age assistance, except that the blind person need not be sixty-five years of age to qualify. Only 184 blind persons as of September 30, 1940 had applied in Connecticut for this special form of relief. Connecticut has the fewest number of beneficiaries on Aid to the Blind of the forty-three states and territories which have plans approved for such by the Social Security Board. It is interesting to note that Maine has 1,210 and that West Virginia, Nebraska and Maryland, each of which has a population almost identical with Connecticut, have respectively 814, 694 and 679 blind beneficiaries under the Aid to the Blind plan. The reason for this marked lack of any considerable attempt on the part of the blind people in this state to secure relief payments on the basis of their handicap is not clear, but is an interesting commentary on the self-reliance of this group. The Aid to the Blind grant makes no provision for medical or eye care, the responsibility for which is placed by the Bureau of Old Age Assistance (the disbursing agency) on the Board of Education for the Blind.

There are only seven conservation of vision classes in Connecticut located in not more than four cities, a number far short of that necessary to attain the objectives of sight conservation in the state. It is apparent that there should be one or more classes in every city of more than 25,000 population, and that specific provision should be made for the conservation of vision of children in need of such assistance living in smaller communities.

The state allows a moderate grant in aid to cities or towns establishing special classes for educationally exceptional children and there is therefore available a backlog of financial assistance for the establishment of such classes. Local boards of education have not been visually minded and superintendents of schools have found it necessary to strain every effort to maintain general services, which means that there has ensued a lack of progress in this field.

An increasingly important problem is the public school child with impaired vision. This is particularly true of the smaller towns and is especially so in some of the towns in the eastern part of the state. These children, with proper correction, can usually be given normal vision or a very considerable amount of sight so that they would not become candidates for conservation of vision classes. In many towns public funds are not available for eye examinations and glasses, and the school nurses who are in touch with cases of eye neglect in school children are not always certain where to obtain the necessary facilities for such help.

Gradually these towns have turned to the Board of Education of the Blind for aid in such emergencies, and as a matter of effective procedure this Board appears to be the appropriate agency through which

such matters should be cleared. Section 1046 RS. 1930 relating to the powers and duties of the Board of Education of the Blind provides in part that this Board "may take such measures in cooperation with other authorities as it may deem advisable for the prevention of blindness or conservation of eyesight . . . " It appears to this Commission that the Board of Education of the Blind should through appropriate measures of publicity and cooperation with school authorities, extend its work in this particular field until it shall have become effectually covered and the necessities cared for.

A CANCER PROGRAM

Cancer is the greatest puzzle in the entire field of health. Its cause is not known and methods of treatment still have limited effectiveness. It causes more deaths in this state each year than any other disease except diseases of the heart, and its occurrence is steadily increasing. While other causes of death have been declining the cancer rate has increased in the last twenty years from 105 per 100,000 of population to 136 per 100,000. It is responsible for four times as many deaths as tuberculosis and as a cause of suffering, economic loss and death it has taken the place of foremost importance.

It is widely realized that the wise approach to this problem is through research into the cause of the disease in order to evolve proper measures for its relief. This research is being carried on by many competent scientists generously financed by private philanthropy. It will become increasingly difficult for the state to disregard all responsibility for the care of some of the persons suffering from this disease and more difficult still to disregard the advantage to be gained from early diagnosis and treatment when some hope for recovery may be held.

There are in the state twenty-one cancer diagnostic clinics that have been voluntarily established by the State Medical Society in cooperation with voluntary hospitals. The State Department of Health has a small Cancer Division that receives an annual appropriation of $5,000 plus a like amount from federal funds. These agencies working together in the closest cooperation constitute the entire state program for the prevention, control and treatment of cancer.

The incidence of cancer in the state is not known. At present the number of cases may only be estimated on a basis of mortality and from the results of some private studies. There are about 2,400 deaths a year from cancer in Connecticut and a commonly accepted formula is that there are between two and three living cases for each death. Using this basis for computation it may be conservatively estimated that there are 6,000 cases in the state. Many of these are unrecognized and will not make themselves known until too late for effective methods for treatment to be employed. It may be fairly estimated that at least one-third

of these 6,000 cases are incapable of meeting the cost of their illness, but if they are diagnosed early and appropriate measures for treatment promptly begun an encouraging number of them may be restored to productive life.

This Commission cannot accurately estimate the amount of money necessary to meet this problem in all of its extent. It is hoped that future measures for the care of the chronically sick as recommended in this report will provide hospitalization and medical service for many of these needy persons who cannot now be cared for because of the inability of general hospitals to take care of chronic terminal cases which require long hospitalization. In some other states special tax-supported hospitals have been established for the care of cancer patients, but such a step is not now believed to be necessary here.

In order to meet immediate requirements this Commission proposes that an annual appropriation of $25.000 be allotted to the State Department of Health to aid in the continuation of the twenty-one existing voluntary diagnostic clinics and such others as may be established. These funds should be used to provide indigent persons and those in the low income group with: (a) x-ray and laboratory diagnosis, (b) consultation and instruction, (c) x-ray and radium treatment. In addition the clinics should be supplied with: (a) social service personnel for case work and follow-up, (b) technical laboratory assistance and (c) a central pathological registry for diagnosed cases.

Connecticut has accepted and is now receiving federal grants for use in the program for maternal health, crippled children and venereal disease and other fields, and in many instances these federal grants have been matched with state appropriations. The theory of federal assistance for continuing service projects such as these has been accepted reluctantly by some who feel that it is contrary to the inherent Connecticut characteristic of self-reliance. Now the pressing need for the beginning of a humane cancer program offers a sharp challenge to assert that self-reliance, and from such a program should come ample return in the relief of suffering and the saving of productive lives.

AN ACT MAKING AN APPROPRIATION TO THE DEPARTMENT OF HEALTH FOR THE STUDY OF CANCER AND MAINTENANCE OF CLINICS

Be it enacted by the Senate and House of Representatives in General Assembly convened:

The sum of fifty thousand dollars ($50.000) is appropriated to the Department of Health, to be used for the study of cancer and the maintenance of diagnostic and treatment clinics for the biennium ending June 30, 1943.

FOOD AND DAIRY PRODUCTS

The Department of Health is properly by law entrusted with the public health of the state. The existing program of the State Dairy and Food Commissioner is almost entirely of a public health character. The activities which have to do with food inspection, including bakeries, restaurants, markets, bottling establishments and taverns may readily be transferred to the Department of Health. Another pressing problem is the development of more uniformity and effectiveness in meat inspection.

It is believed practical and desirable that jurisdiction to regulate the sale of milk and milk products, from the standpoint of consumer protection or public health, be placed in the Department of Health; and that jurisdiction in other matters which are primarily economic and agricultural in nature be placed in the Department of Agriculture. Such a plan is in line with the experience of several states and with suggestions of the U. S. Public Health Service.

There are several thousand milk producers in the state besides other producers who send milk or cream into the state. The sanitary supervision of milk and food is a public health measure and should be handled in the Department of Health. Health Department inspectors are conversant with dairy science, have an insight into the causes and importance of human diseases and have training in epidemology. Their services are especially useful in regard to purity of water supplies, the disposal of human excreta and fly control, as well as in disease follow-up.

It is the opinion of the U.S. Public Health Service that for the following reasons the state program relating to the public health supervision of milk supplies should be assigned to state health departments:

1. Since the state health department is considered responsible for the protection of the public against all preventable disease, all official state duties relating to the public health should be assigned to it.

2. The enforcement of local milk ordinances is always the function of local health departments. Similarly, state duties relating to the public health control of milk supplies should be the function of state health departments.

3. Local health authorities naturally look to the state health authorities for guidance and advisory assistance in public health matters. The assignment of the state functions relating to the public health supervision of milk supplies to a state agency which is not profession-

ally trained in the science of public health would tend to militate against the sympathetic coordination of state and local public health effort which is so essential.

4. If the public health supervision of milk supplies is assigned in whole or in part to any state agency which is subject to the political influence of the industry, influential portions of the industry may attempt to attain commercial ends through public health devices.

For the above reasons the Public Health Service Milk Sanitation Program is based upon the principle that the state milk sanitation program should be assigned to the state health department.

As the Committee on Milk Production and Control of the White House Conference on Child Health and Protection has stated: "Inasmuch as the laws and regulations relating to the public health supervision of milk supplies deal only with the measures which are designed primarily to protect the public health, they should, when practicable, be made the function of health authorities, local, state and federal. The public health supervision of municipal milk supplies should obviously be the function of governmental departments primarily dedicated to the public health point of view and technically trained in the recognition of all public health aspects of the problem."

Whatever legislation is enacted to consolidate the departments having jurisdiction over agriculture, domestic animals, food and dairy products, this Commission is of the opinion that the sanitary supervision of food and dairy products should be lodged with the State Department of Health.

STATE PUBLIC HEALTH SERVICES

The modern public health program in Connecticut, insofar as state organization is concerned, began in 1917 with the reorganization of the State Board of Health and the establishment of the State Public Health Council and the State Department of Health. The major services of the Board of Health had consisted of vital statistics registration, laboratory work and limited communicable disease control activities. Since 1917 the power and duties, personnel and expenditures of the State Department of Health have been increased by action of successive sessions of the General Assembly.

As in a business enterprise, public health work requires trained leadership. Expenditures for carefully planned health programs executed by trained workers yield large dividends. The basis of a satisfactory health service is a well-organized health department, adequately financed, with trained personnel, supported by suitable laws and ordinances, by favorable public opinion and by all professional groups.

The public health problems of a state are so extensive and technical in character that, from the viewpoint of both efficiency and economy, it is essential that the Department of Health be maintained as at present as a major independent unit of government. This policy is supported by opinions of leaders of recognized national health organizations, including the United States Public Health Service, the State and Provincial Health Authorities of North America, and the American Public Health Association.

The basic organization of the State Public Health Council and of the Department of Health, as established by the 1917 General Assembly, is sound and has stood the test of experience. The Public Health Council consists of six members and the Commissioner of Health, all appointed by the Governor for overlapping terms in accordance with good practice. The major functions are:

1. To approve regulations for the Sanitary Code for the protection of health in towns, cities and boroughs.

2. To shape and direct department policies.

3. To sanction appointments and direct department finances.

The present organization is designed to insure stability, continuity of program and policy, and progressive and effective procedures.

It is wisely required by statute that the Commissioner of Health be a physician, graduated from a recognized medical school, of at least five years' experience, skilled in sanitary science and experienced in

public health administration. In view of modern trends, it would be wise to introduce an additional clause requiring a certificate or degree in public health from a recognized department or school of public health.

The major activities of the Connecticut State Department of Health are described in a department leaflet published in 1940, and it is unnecessary to discuss the various features of the work. The Department is well organized and administered and has the confidence of both professional and lay groups. The structure has been built on a sound foundation, and growth has followed lines of the most urgent needs and of tested methods. Other sections of this report deal with essential steps for the extension of services in the fields of cancer, industrial hygiene and mental hygiene.

AN ACT AMENDING AN ACT CONCERNING THE QUALIFICATIONS OF THE COMMISSIONER OF HEALTH

Section 2368 is amended to read: (New material set in heavy type)

Commissioner of Health. The Governor shall appoint a Commissioner of Health, who shall be the administrative head of the Department and Chairman of the Public Health Council. Such Commissioner shall be a physician, graduated by an **acceptable** medical college, recognized by one of the medical examining boards of this state, of at least five years' experience in actual practice of his profession, skilled in sanitary science and experienced in public health administration, **who shall have had a minimum of one year of university graduate instruction in public health, as evidenced by a certificate of graduation or a degree in public health.** The term of office of the Commissioner of Health shall be six years from the first day of July following his appointment. He shall not engage in any other occupation.

EMPLOYMENT OF PROFESSIONAL PERSONNEL

This Commission was specifically requested by the Legislative Council to inquire into the selection of professional personnel for state institutions and the advisability of removing such personnel from the Merit System. This section of this report is added in response to that request. The employment of physicians offers a somewhat unique position in the field of state service. It is a position that is shared in some respects by other specially-trained personnel. Professional and technical staffs require training of a highly specialized nature before entering public employment. Because of this educational requirement, it is reasonable for this class of personnel to expect superior recompense.

A physician employed by the state gains experience through the continuous years of his employment and his usefulness to the state increases thereby, but it must never be lost sight of that this physician is required to have had an expensive, time-consuming education before he is eligible for employment. In pursuing this study this Commission has constantly had this factor in mind and has been motivated by a desire to arrive at an understanding of the conditions of employment of physicians by the state, and to make recommendations that will assure the most satisfactory method for obtaining physicians for public employment, and provide those conditions of employment and recompense that will encourage the continuity of high-grade service.

The State of Connecticut employs on a full-time basis almost one hundred physicians. Extension of present activities that are contemplated in the near future will add about fifteen more to this number. Of this number between 70 and 75 are employed in institutions where housing and maintenance are provided. The remainder are employed mainly in the Health Department where maintenance is not included in the compensation.

Except for the Commissioner of Health who is appointed by the Governor (Sec. 2368, 1930) and superintendents of institutions, all physician employees are included in the Merit System.

The salaries for this group of employees range from $2,100 per annum less maintenance to $7,500 and maintenance. Physicians employed by the State Department of Health receive no maintenance. Prior to the establishment of the Merit System all institutional salaries were computed on a gross salary basis with deductions for maintenance. These deductions vary depending upon the size of the family of the employee and housing provided for their use; and when the Merit Sys-

tem Law went into operation this method of salary estimate was followed. Lately certain appointments have been made on a salary plus maintenance basis, so that at present both methods are followed.

Superintendents of institutions, of which there are nine, are selected on a non-competitive basis by the boards of trustees for mental institutions and by the Tuberculosis Commission for tuberculosis institutions.

All physicians below the grade of superintendent, which includes assistant superintendents, clinical directors, junior physicians, assistant physicians, senior physicians in the institutional services, and all positions in the Health Department other than the Commissioner, are procured by competitive examinations given by the Personnel Director.

Minimum qualifications for each position are established by the Personnel Director in consultation with the employing authority.

Examinations are given under the direction of the Personnel Director by a special committee of physicians who serve on a voluntary basis. (Sec. 442d) To date these examinations have been assembled examinations and have taken the form of oral interviews, giving consideration to training, experience, special qualifications and the results of the oral interview.

The Merit System Law requires that all applicants be citizens of the United States and residents of the State of Connecticut for two years prior to application. Under certain conditions the Personnel Director may waive the residence requirement. (Sec. 451d) The law further states that no requirements as to formal education shall be established for the taking of such examinations. (441d)

The State of Connecticut offers no large pool of available physicians for such employment. This is particularly true in the higher-grade positions. The recruiting for these positions limited to residents of the State of Connecticut is a practical impossibility, and it has been necessary in almost every instance to waive the residence requirement and seek applicants from outside of this state. There appears to be no reason to anticipate that this state of affairs will change.

Because there is no considerable pool of employable physicians in the State of Connecticut, it has, as noted above, become necessary to recruit from outside the state. Requiring candidates to appear before the examining committee entails expense and hardship upon such applicants who are reluctant to come to Connecticut at their own expense to appear before a board in a competitive examination when there is no certainty of obtaining employment. This factor has served as an impediment to developing a large number of applicants.

One of the basic theories of the Merit System and the competitive examination is the establishment of an eligible list from which appointments may be made. In actual practice in this state, eligible lists of

physicians have been of little practical advantage. In the first place, the number of applicants is small and there are always some excluded for lack of qualifications or knowledge; and the resulting lists have often included so few that after one or two appointments were made from the list it was no longer effective because of waivers of employment on the part of applicants to whom positions were offered. As must be expected, if a position has not been offered within a reasonable time following the examination, the applicant has sought and found employment elsewhere and is no longer available to the State of Connecticut. This necessitates holding another examination and establishing another list, a procedure that is time-consuming, cumbersome and expensive.

It is customary for physicians employed in institutions to receive housing and subsistence in addition to their cash salaries. There are many reasons why this is desirable. Various methods are followed in the several states to fix the value of this maintenance. From the studies made by this Commission it appears the commonest practice for states to pay a given cash salary and in addition to that allow full maintenance for the employee and his immediate dependent family. This system is not followed in the State of Connecticut with a few exceptions, and the plan in practice here is the so-called Griffenhagen System in which an attempt is made to compute the value of the maintenance received by the employee, and this value varies with the number of persons in the employee's family to be maintained. Theoretically such a system has some merit. Actually, however, it makes for confusion and occasionally inequity. The chief reasons for placing a value upon maintenance are: (a) gross salary income for the computation of income taxes and (b) gross salary payment for purposes of computation of retirement pay, since the Connecticut law provides retirement on the basis of gross salary including maintenance and not upon the cash salary received.

Minimum and maximum salaries are established for the various grades of employment, but increases within those salary brackets are not regular nor can they be anticipated with any assurance. Salary increases within the bracket depend upon recommendation of the employing authority, allowance by the Budget Director and approval by the Personnel Board. This method makes for uncertainty with respect to salary increases and is a hinderance to continuous, progressive employment in the development of a permanent, satisfied professional staff.

The Merit System Law allows an employing authority to name provisional employees when such employees cannot be obtained from an eligible list. It is required that provisional employees must take the first competitive examination for the position that is given following their appointment. Acceptance of a provisional appointment involves

uncertainty on the part of the appointee in that he has no assurance that after having served in the position for a time as a provisional appointee he will receive a permanent appointment because, as a result of the competitive examination, it may be that another will receive a higher grade in the examination and must perforce be appointed. Again referring to the lack of nearby applicants, desirable provisional appointees are reluctant to remove to this state—and this sometimes entails moving a family—upon so tenuous a possibility of obtaining permanent employment.

Recommendations.

1 **Educational Requirements.** The restriction imposed by Section 685e, which states, "No requirement as to formal education shall be established for the taking of such examinations," is absurd insofar as it applies to physicians. No person is eligible to practice medicine in the State of Connecticut unless he is a graduate of an accepted medical college, nor can any person be employed by the state as a physician unless he has satisfied that educational requirement. At present this defect in the law is circumvented by various implications, but it is clear to this Commission that the Merit System Law should specifically state that a person seeking state employment as a physician should be required to present a degree in medicine from an accepted school. To that end it is recommended that Section 685e be appropriately amended to require this qualification.

2. **Method of Procurement.** In order to simplify and make more expeditious the procurement of physicians for employment in the lower grades, it is recommended that eligible lists in the grade of junior hospital physician and assistant hospital physician be established by non-assembled examinations. The procedure recommended by this Commission is: Following announcement of the examination, applicants should be allowed to submit records of their training, qualifications and recommendations in some detail, and these candidates would then be graded by a committee appointed by the Personnel Director, as at present. This grading would be made solely on the basis of their written application and they would not be required to appear in person before the committee. An eligible list would be thereby established and the first three on such list certified to the employing authority for appointment. Prior to appointment the employing authority would summon his choice among the first three for an interview. If, during that interview, the applicant did not meet the requirements of the employing authority, such authority would be privileged to select another of the persons certified.

3. **Promotion.** It is recommended that the present method for promotion to a higher grade be continued.

4. **Salary Increases.** It is recommended that a fixed schedule of salary increases be established within each salary bracket so that an appointee will enter employment at the minimum for that bracket and by regular annual or biennial steps receive a known salary increase until he reaches the maximum for the bracket, such increases to be subject to recommendation from the employing authority. That is to say that an employee rendering satisfactory service to the institution will be assured of regular and predetermined salary increases to a given maximum; and failing to receive the recommendations for these stated increases because of inefficiency would be provocation for a suggestion that the employee seek employment elsewhere, or be reason for dismissal.

AN ACT AMENDING AN ACT CONCERNING EXAMINATIONS FOR STATE EMPLOYEES

Section 658e is amended to read: (New material set in heavy type)

Section 658e Examinations; character . . . No requirement as to formal education shall be established for the taking of such examinations, **except that physicians and dentists shall be licensed to practice medicine or dentistry in this state, or eligible for such license.**

THE LICENSING OF PHYSICIANS

The governing factor for determining the quality of medical care in any locality must be the quality of physicians that render that care, whether they be public employees or individual practitioners. There is but one place where that quality may be determined, one place where the public may be protected from inadequately-trained physicians. That place is the licensing examination given by the State Medical Examining Board. This Board is the first and almost the only line of defense the public has to protect the quality of its medical care. If the Board lowers its standards or if the statutes regulating the conduct of the Board are weakened, the whole complex structure of medical care will be affected.

The Connecticut State Medical Examining Board has served the people of this state with fine diligence and integrity and has for fifty years been a safeguard to the quality of medical care in the state. The failure rate before the Connecticut Medical Examining Board is high. It has been consistently higher than the average of the country as a whole for many years. For the five years just ended 28.01 per cent of the candidates who appeared before this Board failed to pass its examinations, a failure rate that is exceeded by only one state in the nation.

This Commission wishes to direct attention to the importance of maintaining this high standard for physicians seeking the privilege to practice medicine in the state.

STUDY OF THE CONDITIONS AT THE NORWICH STATE HOSPITAL

Soon after the original organization of the Commission and while it was occupied in drawing up its agenda and developing a program for its activities, the Governor asked the Commission to direct its immediate attention to a study of the conditions at the Norwich State Hospital. This study was pursued with care and the whole of the time of the Commission's activities was devoted to this study for the first several months of its existence.

A report of the Commission's findings at the Norwich State Hospital was submitted to the Governor on November 15, 1939. A list of the hearings and meetings of the Commission held in connection with this study is included in the appendix of the present report, and a copy of the Report of November 15, 1939 has been filed in the State Library.

FURTHER STUDIES

The Legislature of 1939 in creating this Commission placed upon it the duty of studying the problems presented by the physical and mental disabilities of the people of the state, and directed it to inquire into the subject of the expenditures made or in the opinion of the Commission necessary to be made by the state for the prevention of such disabilities and the care of the people afflicted by them.

Authority was thus given for a survey of the state's resources in the prevention, care and treatment of sickness, both physical and mental. It was incumbent upon the Commission to determine whether these resources had been wisely used, whether results already obtained were commensurate with the expenditures involved, whether better results might be obtained through the coordination of existing services and whether other facilities should be provided or rearrangement made of those functioning.

To these considerations the Commission has addressed itself and they are met in part by the recommendations of the Commission appearing in the preceding pages of this report. These recommendations have to do with what appears to the Commission to be pressing necessities of state policy requiring legislative consideration and action.

With these immediate problems considered and recommendations made concerning them, there still remain many questions directly concerned with the health and well-being of the people of the state which require further study and consideration if these problems are to be properly met.

A. **A School Health Program.** The greater number of future citizens of Connecticut will come up through the schools. The processes of education have no greater responsibility than to insure a sound body as an accompaniment of a sound mind. Instruction in health and the maintenance of health of school children are matters of first concern and deserving of extended study. From such a study should come a definite state policy concerned with these essentials of public health.

B. **The Care of the Chronically Sick.** This consideration and recommendation for further study has been set forth elsewhere in this report.

C. **Coordination of State and Local Agencies.** There remain for study many factors not considered by this Commission which relate to the proper and advantageous coordination of state and local public and private agencies concerned with the protection of the public health. The relationship of these organizations is such that further study should reveal opportunities for better integration of their efforts that would insure economies in their administration and increase their public usefulness.

D. **Medical Service for Individuals.** The health of every individual is a social concern and responsibility. There are groups of people above the grade of indigency in every community who find themselves economically unable to provide for adequate medical care, especially when overtaken by severe illness. Medical care for these people is available in this state but its purchase is often difficult. There is a popular demand for a device that will make more medical service readily obtainable by more people, but the exact extent of the real necessity is not known.

In the near future the state should direct its attention to this question, which is one of increasing economic importance. Its solution will require careful study and thoughtful judgment, giving appropriate consideration to the necessity for the use of public funds and public supervision for such service.

SUPPLEMENTAL STUDIES

At the request of this Commission three departments of the state government have made special studies; these are listed below:

The State Department of Health.

1. Water supply, milk supply and sewage disposal—The Seaside Sanatorium.

2. Water supply, milk supply and sewage disposal—Laurel Heights Sanatorium.

3. Water supply, milk supply and sewage disposal—Cedarcrest Sanatorium.

4. Water supply, milk supply and sewage disposal—Undercliff Sanatorium.

5. Water supply, milk supply and sewage disposal—Uncas-on-Thames Sanatorium.

6. Water supply, milk supply and sewage disposal—Connecticut State Hospital, Middletown.

7. Water supply, milk supply and sewage disposal—Norwich State Hospital.

8. Water supply, milk supply and sewage disposal—Fairfield State Hospital.

9. Water supply, milk supply and sewage disposal—Mystic Oral School.

10. Water supply, milk supply and sewage disposal—Mansfield State Training School and Hospital.

State Police Department.

1. Fire hazards and fire escape provisions—Connecticut State Hospital, Middletown.

2. Fire protection—Mystic Oral School.

The Tuberculosis Commission.

1. A survey of the incidence of tuberculosis among all of the inmates and employees at the Mansfield State Training School and Hospital.

The Department of Finance and Control and the Department of Welfare have placed at the disposal of this Commission special statistical studies and records.

MEETINGS, CONFERENCES AND INQUIRIES HELD BY THE COMMISSION

Date	*Place*	*Object*
1939		
Aug. 14	New Haven	Organization
18	Norwich	Inquiry—Norwich State Hospital
21	New Haven	Staff Inquiry—Norwich State Hospital
28	Norwich	Inquiry—Norwich State Hospital
Sept. 12	New Haven	Executive
14	Norwich	Inquiry—Norwich State Hospital
18	New Haven	Executive
Oct. 6	Hartford	Reorganization of Commission
9	Norwich	Inquiry—Norwich State Hospital
12	Norwich	Inquiry—Norwich State Hospital
13	Norwich	Inquiry—Norwich State Hospital
17	Norwich	Inquiry—Norwich State Hospital
19	Norwich	Inquiry—Norwich State Hospital
20	Norwich	Inquiry—Norwich State Hospital
22	New Haven	Executive
25	Norwich	Inquiry—Norwich State Hospital
27	Norwich	Inquiry—Norwich State Hospital
28	Norwich	Inquiry—Norwich State Hospital
29	New Haven	Executive
Nov. 1	Norwich	Inquiry—Norwich State Hospital
9	Norwich	Inquiry—Norwich State Hospital
20	New Haven	Executive
28	Hartford	Conference—State Commissioner of Health
Dec. 9	New Haven	Executive
16	New Haven	Executive
23	New Haven	Executive
1940		
Jan. 6	New Haven	Executive
13	New Haven	Executive
16	New Haven	Executive
27	Hartford	Conference—Trustees, Fairfield State Hospital
Feb. 3	Hartford	Conference—Trustees, Conn. State Hospital
8	Newtown	Conference—Staff, Fairfield State Hospital
17	Hartford	Conference—Trustees, Mansfield State Training School and Hospital
24	New Haven	Conference—Trustees, Southbury Training School
28	Middletown	Conference—Staff, Connecticut State Hospital
Mar. 2	New Haven	Conference—Probate Assembly
7	Middletown	Conference—Staff, Connecticut State Hospital
16	New Haven	Conference—Probate Court authorities of Middletown and Norwich Public Welfare Council and Commissioner of Welfare
25	Hartford	Executive
26	Groton	Inquiry—Mystic Oral School

MEETINGS, CONFERENCES AND INQUIRIES HELD BY THE COMMISSION (Continued)

Date	*Place*	*Object*
Apr. 6	Hartford	Conference—Education of the Deaf. Commissioner of Education
16	New London	Conference—Trustees, Mystic Oral School
19	West Hartford	Conference—Trustees, American School for the Deaf
22	Hartford	Conference—Commissioner of Public Works
May 2	Hartford	Conference—Trustees, Mystic Oral School
17	Mansfield	Conference—Mansfield State Training School
27	New Haven	Conference—Education of the Deaf
June 17	New Haven	Conference—Personnel Director Conference—Tuberculosis Commission
24	New Haven	Conference—Superintendents of State Mental Hospitals
Aug. 29	New Haven	Executive
Sept. 5	New Haven	Conference—Commissioner of Health Conference—Director, Bureau of Mental Hygiene Conference—Superintendents of Tuberculosis Sanatoria
27	Hartford	Conference—Social Workers and Hospital Administrators
Oct. 20	New Haven	Executive
30	New Haven	Executive
Nov. 14	Hartford	Public Health Council
25	New Haven	Executive
30	New Haven	Executive
Dec. 3	New Haven	Executive
6	New Haven	Executive
10	New Haven	Executive
13	New Haven	Executive
18	New Haven	Executive
20	New Haven	Executive

In addition to the above, members of this Commission have visited institutions and conferred with administrators and others in this state and the states of Massachusetts and New York. Statistical material and other information have been obtained through correspondence with public officials and private citizens in many states throughout the Union.

CONCLUSION

This Commission has had an unequaled opportunity to appraise every public measure for the prevention, care and preservation of the health of the people of the state. It has not been limited to the consideration of any single field or function. Because of the wide latitude of the study, it has not been possible to apply detailed scrutiny to each institution, as was especially done in one instance.

It may appear that discussion of some parts of the state program is not included in this report. That omission is not a matter of neglect but is due to the fact that as the study progressed those parts became contributory to larger fields of consideration which are finally presented.

From the beginning of its deliberations the Commission has been inclined toward reasonable economy in the operation of the state health and welfare program. Actually, however, it has been difficult to find places where expenditures may be reduced if adequate and expected services are to be maintained. This state is not extravagant in its provisions for the care of its sick and unfortunate, and the knowledge this Commission has gained brings the conclusion that those provisions should be wisely and humanely extended rather than curtailed during the years that lie ahead.